DOCUMENT RESUME

ED 345 393 EC 301 152

AUTHOR Isaacs, Mareasa R.; Benjamin, Marva P.
TITLE Towards a Culturally Competent System of Care. Volume II: Programs Which Utilize Culturally Competent Principles.
INSTITUTION Georgetown Univ. Child Development Center, Washington, DC. CASSP Technical Assistance Center.
SPONS AGENCY National Inst. of Mental Health (DHHS), Rockville, MD. Child and Adolescent Service System Program.
PUB DATE Dec 91
NOTE 298p.; For Volume I, "Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed," see ED 330 171.
AVAILABLE FROM CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center, 3800 Reservoir Road N.W., Washington, DC 20007.
PUB TYPE Reports - Descriptive (141) -- Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC12 Plus Postage.
DESCRIPTORS Agency Cooperation; Community Programs; *Cultural Awareness; *Cultural Differences; Demography; Elementary Secondary Education; *Emotional Disturbances; Ethnic Groups; Evaluation Methods; *Mental Health Programs; Minority Groups; National Surveys; *Program Development; Program Evaluation; Program Implementation

ABSTRACT

This monograph was developed to assist states and communities in planning, designing, and implementing culturally competent systems of care for children with serious emotional disturbances. It highlights the culturally competent aspects of 11 programs serving people of color. Each program targets at least one of the four major ethnic minority groups in the United States and involves cooperative services from more than one system. The programs were identified as a result of a nationwide survey and site visits. Chapter I presents background information including the changing demographics of the United States and principles of cultural competence. Chapter II focuses on six basic questions such as who defines mental health and illness, accessibility of mental health services to ethnic minorities, intervention methods, and evaluation of outcomes. Other issues examined include program philosophy and policies, program location, types of services offered, cultural assessments, ethnic-specific staffing patterns, service linkages, and treatment goals and evaluation. Chapter III summarizes critical aspects of the cultural competency model. Chapter IV contains the program descriptions of the 11 programs. For each program, the following information is presented: a history and identification of the agency, a community description, the target population, program philosophy and goals, type of services, funding strategies, evaluation mechanisms, and how cultural competence principles are addressed. Appendices provide administrative forms, profiles of programs/agencies not site visited, a list of participating agencies, and a list of faculty of the Culturally Competent Training Institute. (80 references) (DB)

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TOWARDS A CULTURALLY COMPETENT SYSTEM OF CARE
Volume II

Programs Which Utilize Culturally Competent Principles

December 1991

By
Mareasa R. Isaacs, Ph.D.
and
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CASSP Technical Assistance Center
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Volume II

Programs Which Utilize Culturally Competent Principles

Prepared by:

Mareasa R. Isaacs, Ph.D.
and
Marva P. Benjamin, ACSW

with the assistance of the
CASSP Minority Initiative Resource Committee

December 1991

This project is funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)

Available from:

CASSP Technical Assistance Center
Center for Child Health and Mental Health Policy
Georgetown University Child Development Center
3800 Reservoir Road, N.W.
Washington, DC 20007
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ACKNOWLEDGEMENTS

As the second volume of a two-volume series, this companion monograph is the major product of a study highlighting program examples which utilize cultural competence principles. Just as Volume One was made possible through the commitment, dedication, hard work, and expertise of the Child and Adolescent Service System Program (CASSP) Minority Initiative Resource Committee, Volume Two is equally indebted to this committee, membership listed below, for its guidance, support, direction, and resourcefulness.

William Arroyo, M.D., University of Southern California, Los Angeles, CA
Barbara J. Bazron, Ph.D., Pittsburgh New Futures, Pittsburgh, PA
Marva P. Benjamin, ACSW, Georgetown University, Washington, DC
John Castillo, MSW, Southern California Indian Center, Inc., Garden Grove, CA
Lemuel Clark, M.D., National Institute of Mental Health, Rockville, MD
Terry L. Cross, MSW, Northwest Indian Child Welfare Institute, Portland, OR
Karl W. Dennis, Kaleidoscope, Inc., Chicago, IL
Sybil K. Goldman, MSW, Georgetown University, Washington, DC
Rachel G. Guerrero, MSW, Department of Mental Health, Sacramento, CA
Jerome H. Hanley, Ph.D., Department of Mental Health, Columbia, SC
Mario Hernandez, Ph.D., Ventura County Mental Health, Ventura, CA
Regenia Hicks, Ph.D., Mental Hygiene Administration, Baltimore, MD
Mareasa R. Isaacs, The Isaacs Group, Washington, DC
Dixie Jordon, PACER Center, Minneapolis, MN
Judith Katz-Leavy, National Institute of Mental Health, Rockville, MD
Joseph C.Y. Lam, Chinatown Youth Center, San Francisco, CA
May Kwan Lorenzo, Ph.D., ACSW, Consultant, Boston, MA
Ira S. Lourie, M.D., Consultant, Human Service Collaborative, Washington, DC
Bernie Manning, Ph.D., Pittsburgh Public Schools, Pittsburgh, PA
Maxwell Manning, ACSW, Brooklyn Children and Family Services Network, Brooklyn, NY
James L. Mason, Portland Research and Training Center, Portland, OR
Denise Rosario, ACSW, Coalition for Hispanic Family Services, Brooklyn, NY
José S. Soto, J.D., Lincoln Action Program, Inc., Lincoln, NE
Velva R. Spriggs, MSW, Family Advocacy and Support Association, Washington, DC
Kenley R. Wade, M.M., Department of Mental Health and Developmental Disabilities, Springfield, IL
Nancy Ware, Commission on Mental Health, Washington, DC

We are especially grateful to the subcommittee which was co-chaired by Barbara Bazron and Karl Dennis and included Terry Cross, Mareasa Isaacs, Nancy Ware, Kenley Wade, Denise Rosario, May Lorenzo, and William Arroyo. This group took major responsibility for the design of the project.

We owe Ira Lourie, former Director of CASSP, Judith Katz-Leavy and Lemuel Clark of the National Institute of Mental Health, and Phyllis Magrab and Sybil Goldman of Georgetown University, our thanks for their national leadership in advancing the goal of providing effective services to children of color who are seriously emotionally disturbed and for their families. Sybil Goldman and Lemuel Clark have been outstanding in their support of our efforts.

Most importantly, the administrators, staff, board members, family members, child and adolescent clients, and staff from other community agencies involved in this study provided a wealth of information, experience, and knowledge which made this volume of the monograph possible. Their contributions to this project are acknowledged and appreciated:

Asian/Pacific Center for Human Development, Denver, CO
Black Family Development, Inc., Detroit, MI
Roberto Clemente Family Guidance Center, New York, NY
The Indian Health Board of Minneapolis, Inc.,
The Soaring Eagles Program, Minneapolis, MN
Ada S. McKinley Intervention Services, Chicago, IL
Progressive Life Center, Inc., Washington, DC
Roybal Family Mental Health Services,
Utah Street School Co-Location Project, Los Angeles, CA
Santa Clara County Mental Health Bureau, San Jose, CA
South Cove Community Health Center, Boston, MA
Three Rivers Youth, Pittsburgh, PA
U.S. Public Health Service, Mental Health/Social Service Program,
Yakima Indian Reservation, Toppenish, WA

We are also grateful to Helen Fritzel, CASSP Administrative Assistant, for her skill, patience, and dedication in working on the monograph and for the numerous hours she spent in typing its various drafts.

Finally, we would like to thank the hundreds of individuals and agencies across the country who nominated programs that exemplify principles of cultural competence. Without the cooperation and contributions of the 98 programs that participated in our telephone interview process, this monograph would not have been possible.

Mareasa Isaacs, Ph.D., The Isaacs Group

and

Marva Benjamin, ACSW, Georgetown University

PREFACE: A PARENT'S PERSPECTIVE

I've been in the mental health services arena for a number of years, initially as a social worker, later as a parent of a child with emotional problems, and currently as president of the Family Advocacy and Support Association, a support group for parents of children who are seriously emotionally disturbed in the District of Columbia. As an advocate for improving the service delivery system for children of color and their families, I am a stakeholder, both personally and professionally, in efforts to ensure that the system of care is culturally competent.

For a long time, I've heard variations on the theme of culture as it pertains to people of color. For instance, there was Daniel Moynihan's famous statement in the 1960s that African Americans – at that time, Negroes – "had no culture to guard or protect." (Can you imagine the social policies and programs that would have emanated – and did, in some cases – from such thinking?) Since then, however, there has been a significant movement across cultures, communities, and professions to embrace the view that there are indeed cultures beyond mainstream America that are rich, complex, historical, and that, for the most part, predate Eurocentric thought and culture. What a distance for the society to have come over the short span of our lifetime.

And yet, there is the need to continue the dialogue and training essential to increasing the cultural competence of professional human service workers as they serve America's diverse non-European, ethnic populations, frequently referred to as minorities. There must be a continuing examination by all professionals of their values and behaviors which could, if not checked, become barriers to service delivery. And each barrier could represent a lost opportunity to help a minority child and his or her family along the road to sound mental health.

The need for mental health services for minority children and their families is increasing. This is due, in part, to factors that increase their vulnerability in the society and render them at greater risk of experiencing problems of homelessness, abuse and neglect, drug and alcohol addiction, AIDS . . . and the list goes on. The need for cultural competence in reaching these children and their families is NOT NEGOTIABLE. Without such competence, many of these potential clients will be lost to the "Americanized" systems of mental health care. (Once Americanized, these systems will not reflect the pluralism of the society in which they exist.)

Someone once referred to cultural competence in service delivery as an ethical imperative. This is a powerful idea. It is also an empowering concept because it demands respect for cultural diversity in human beings and it is unequivocal in making that demand. A human service delivery system, conceived and administered without an understanding of cultural diversity and a commitment to taking that diversity into account in service delivery, training, policy development, and evaluation, is not only an institution born of unearned arrogance, but also one likely to provide inappropriate, ineffective, and potentially damaging services.

Dare we dream about the quality and quantity of services provided by culturally competent governments, their agencies, and private providers? First of all, services must be accessible and available when needed. If outreach is more appropriate than traditional one-hour office visits, such a service must be provided. If families are viewed as extended – as opposed to being nuclear – service approaches must be developed to accommodate this definition.

If a mental health agency includes in its decor items or pictures that depict children of color, a powerful message is conveyed. Thus, when Asian or Hispanic American children see a picture of someone on the wall who looks like them, they might say, "I, too, am someone worthwhile. I am beautiful. Pictures of people like me are worthy of hanging on the wall." If African American children tend to be tactile, then touch them (appropriately, of course), if this increases the comfort level. Hugs can be okay. If Native American children are taught not to look directly at you as a sign of respect, don't infer that this means something other than what their culture dictates. We people of color do not arrive at your doorstep without a past, a family, a community. You must see us within the context of those forces which have shaped us, and which may be different in some way from those forces which have shaped members of the majority culture. Different, but no less valid or validating.

Fortunately, there are some programs within the United States that have adapted their services to meet the needs of children of color and their families within a cultural context. These programs underscore the importance of family and community traditions in determining service models and intervention strategies. Concomitantly, an essential factor in making such a determination relates to the dynamics of ethnicity and culture. The programs described in this monograph contend that without viewing these dynamics as critical in determining service delivery approaches, service effectiveness will be minimal.

We, members of the CASSP Minority Initiative Resource Committee, invite you to explore and apply, when appropriate, the many service philosophies and intervention approaches outlined in this volume of our monograph. It is expected that you will discover some of the unique and creative ways that programs have responded to the mental health needs of people of color while enhancing the overall benefits of the services provided.

Where there is a will, there's a way!!

Velva Spriggs, President*
Family Advocacy and Support Association
Washington, DC
CASSP Minority Initiative
Resource Committee Member

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*The program descriptions were reviewed from a parent's perspective by Velva Spriggs. A summary statement which highlights a significant feature of each effort appears at the beginning of each program description.

INTRODUCTION

This document is the second of a two-volume series on culturally competent systems of care. Volume One, entitled *Towards A Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*, was published in March 1989 by the Child and Adolescent Service System Program (CASSP) Technical Assistance Center at Georgetown University. This volume was developed to assist states and communities in planning, designing, and implementing culturally competent systems of care.

Volume One provided a philosophical framework, identified principles for a culturally competent system of care, and contained practical ideas for improving services for African American, Asian American, Latino/Hispanic, and Native American children/families. Volume One was well received in the field and, in fact, is considered by many as a pioneering document. It has proven to be a useful tool for consumers, practitioners, administrators, and policymakers who have started the developmental task of improving the service delivery system for children of color and their families.

In introducing the culturally competent system of care philosophy to the field, Volume One has proven useful in identifying culturally competent values and principles that are applicable to any human service organization, program, agency, or individual providing services to minority group members. This is reflected in the numerous requests received to provide training on culturally competent approaches to service delivery, and the technical assistance and consultation provided on such approaches to a variety of local, state, and national organizations/agencies in the human service, health, and education fields.

In order to receive maximum benefit from Volume Two of the document, it is strongly recommended that the reader examine Volume One since both documents were designed as companion pieces. Indeed, the values and principles of a culturally competent system of care referenced in Volume One served as the foundation upon which Volume Two was based. As such, Volume Two highlights the culturally competent aspects of 11 programs that exemplify specific components of the culturally competent system of care principles. It should be emphasized that the program examples cited in the monograph were not necessarily selected as model programs. They are presented as good examples of programs serving people of color. It is, of course, recognized that there are many other programs in the field that also provide effective services for minority children who are seriously emotionally disturbed and for their families.

Volume One posits the concept of cultural competence as a developmental process and a goal toward which agencies can strive. Volume Two, through the background information provided, the lessons learned from the program sites, and the program descriptions which follow, also makes it abundantly clear that there is considerable room for growth. Each of the programs

described targets at least one of the four ethnic minority groups in this country. Each program also serves children and families of color who require services from more than one system that serves children. In many ways, each program is unique because each has chosen to operationalize one or more of the cultural competence principles which address the specific needs of the population and community it serves.

In the appendix section of this monograph, two tables summarize data from an additional 72 of the 98 programs which responded to a nationwide survey of culturally competent programs. These programs represent every region of the country and encompass 26 states. Since the information contained in the agency profile section was collected through structured telephone interviews which took place in the winter of 1989, it may not be the most current information available. Moreover, 15 of the programs which were screened are not summarized in this monograph because, either they served adults only, did not complete the interview process, or several programs of a particular agency were combined into one agency profile.

The process leading to the selection of programs ultimately chosen as study sites for this monograph is described below. Prior to summarizing this process, however, it should be stated that, in addition to developing this monograph series, CASSP also sponsored an intensive Training Institute on Cultural Competence in Boulder, Colorado, on July 22-26, 1990. The 11 programs featured in this monograph were presented and discussed at these Training Institutes. A list of faculty members for the institutes can be found in Appendix IV.

The nationwide survey referred to above identified programs which were perceived as having made a commitment to adapting their services to meet the needs of minority children, their families, and communities within the context of their culture. The identification and selection process involved distributing 14 hundred nomination forms (Appendix I) in August 1989 to key informants from mainstream agencies and organizations, to ethnic-specific organizations, and to human service professionals of color. As a result of this process, 136 nominations from 35 states, including the District of Columbia were received and considered. A screening survey instrument (Appendix I) was mailed to each of the 136 nominated programs in preparation for collecting information about those programs/agencies. The screening instrument was used as a guide to collect the information through extensive telephone interviews with agency/program executives. A few programs chose to mail in their completed questionnaires.

In January 1990, data from the 98 programs which responded to the survey was carefully reviewed by the CASSP Minority Initiative Resource Committee. Factors considered for the selection of programs to be visited and subsequently for inclusion in this document were: geographical diversity, population served, type of community, services provided, age range of clients, staff training on culturally competent issues, and the extent to which culturally competent principles are utilized at four different levels of service delivery – policymaking, administrative, practitioner, and consumer. As a result of this process, 16 programs were recommended for a second telephone interview. Eleven of these 16 programs were selected for two-day site visits. Site visits took place between April and June of 1990.

During site visits to the selected programs, a structured interview guide was utilized to ensure that a common set of issues would be addressed in the interviews and that uniform information would be gathered from each of the program sites. The site visit process included interviews, discussions, and group meetings with representatives from all levels of the organization. This included administrative, clinical, program, and budget staff, as well as board members. Interviews and discussions were also conducted with family members, child and adolescent clients, and other community agency representatives where appropriate.

It was observed during the site visits that incentives for a program to move toward a culturally competent system of care were directly related to the political climate and support from funding and policy agencies at the local, state, and federal levels. Therefore, it was deemed important to conduct a state survey to determine how states were addressing cultural competence issues. This survey was completed in April 1991 and the resulting analysis is currently being prepared for distribution to the field.

The analysis of information compiled from the culturally competent program examples involved synthesizing the information obtained from the telephone survey, site visits, the state surveys, and a literature review on culturally competent programs/systems.

In summary, Volume One was developed to assist administrators, policymakers, practitioners, and consumers meet the challenge of effectively serving minority children and their families. Similarly, it is expected that the information contained in Volume Two can further assist state and local programs to improve the delivery of services to minority populations and increase the cultural competence of agencies and practitioners. It is felt that the program examples described in this monograph illustrate how culturally competent principles can be made operational to better serve children of color and their families. In that respect, the reader should bear in mind that becoming culturally competent is an ongoing process and that the programs cited in this volume are at varying stages of development as they move toward the goal of cultural competence. Additionally, the reader should also keep in mind that it is not the intent of this document to provide replication strategies or to present model programs. Rather, it is intended that the reader examine each program's philosophy and values in relationship to the dynamic process of movement toward becoming culturally competent.

Regrettably, it was not possible to include program descriptions for all of the programs identified during the nationwide survey. It is felt, however, that those programs which are included do illustrate certain principles of a culturally competent system of care such as outreach, creative use of the natural support systems, and an emphasis on the family as the primary system of support and the preferred point of intervention.

After carefully examining the remainder of this document, it is hoped that the reader will have gained additional insight and acquired new knowledge toward the goal of better understanding the culturally competent approach to service delivery. Toward that end, we have organized the remaining content of this monograph as follows:

Chapter I includes background information which provides a context for understanding why cultural competence is seen as a very important issue. The changing demographics of the United States are addressed and the cultural competence principles are restated. The literature, as it relates to cultural competence issues, is reviewed and the analysis of this review begins to answer the question of why it is important to become culturally competent.

Chapter II, while exploring ways to move towards culturally competent systems of care, focuses on six basic questions or issues that should be addressed by mental health policymakers, practitioners, and other service providers if services to minority populations are to be effectively implemented. This chapter also provides an analysis of issues addressed by one or more of the 11 programs which are highlighted in this monograph. Such cross-cutting issues as program auspices; philosophy and policies; location of programs; types of services offered; emphasis on the importance of family; cultural assessments; ethnic-specific staffing patterns and recruitment/retention strategies; training, education, and curriculum development; service linkages; and treatment goals and evaluation are all addressed in this chapter.

Chapter III provides a summary of some critical aspects of the cultural competence model. It also provides some suggestions and recommendations regarding future directions that could be taken to further assist the field in moving toward a culturally competent system of care.

Chapter IV contains the program descriptions of the 11 programs included in this monograph. The format for these program descriptions includes a brief history and identification of the agency, a description of the community in which the program is located, an identification of the target population, a statement of the program philosophy and goals, the type of services provided, the funding strategies, and the mechanisms used for evaluating the effectiveness of these services. The program descriptions also include an analysis of how cultural competence principles are addressed or operationalized.

CHAPTER I

BACKGROUND: THE CULTURAL IMPERATIVE

Perhaps the decade of the 1990s will best be known as the years of the "cultural imperative" in the United States. By this, we mean that never before has the whole issue of race and ethnicity had such saliency for so many American institutions. The whole notion of cultural competence, cultural diversity, multiculturalism, pluralism, and a host of other such terms has come to dominate discussions and debates in almost every aspect of national policy and in calls for reforms of core American institutions, especially businesses and the education system from preschool/elementary levels to our most prestigious settings for higher education. Daily in American newspapers and periodicals, as well as through television and radio, the issue of the role of culture/ethnicity and the multicultural nature of the population is drawing increasing attention.

The whole notion of cultural competence also has critical and far-reaching implications for all those American institutions expressly designed to provide assistance, services, and rehabilitation to children and their families. In addition to the schools, these include child welfare, child mental health, juvenile justice, child health, and substance abuse agencies. In the case of the service systems for children and their families, the concept of cultural competence has even more urgency since, increasingly, the children and families receiving services in these primarily public sector systems are ethnic minorities.

At the same time, the neglect and deterioration of American children and child/family services has reached almost epidemic crisis proportions. Again and again, lawsuits are brought against the poorly functioning and sometimes destructive practices of those systems designed to protect and nurture our children. As Sylvia Ann Hewlett indicates in her book, *When The Bough Breaks* (1991), all children in this country are at risk. But disadvantaged children – most of whom are ethnic minorities – have a resource deficit. She notes that "the number of children growing up below the poverty line rose from 16 percent in 1979 to 20 percent in 1988. Two and a quarter million more children are poorer today than in 1980, swelling the ranks of America's poor children to almost 13 million" (p. 35). As will be seen in the discussion of demographic shifts in the American population, the ethnic minority groups which are the focus of this document tend to be younger and have more children than their Euro American counterparts. Therefore, they are disproportionately impacted by poverty and other resource deficits related to children and family life.

Focus on Culture and Ethnicity

There are many people who become unsettled and uneasy with the increasing emphasis and focus on culture and ethnicity, especially as it relates to ethnic minorities in this country. It is tempting to focus on social class, or gender, or geography as major explanations for inequities and differential treatment in society. Of course, these factors do play a role in societal imbalances, but race and ethnicity are also critical factors that we can no longer afford to ignore. Yet, when

the issue of race or ethnicity comes into the equation, there is often noticeable tension and discomfort. The legacies of racism, oppression, and discrimination – which race and ethnicity issues arouse – are still unacceptable and untenable concepts that most Americans ignore or pretend do not exist. These issues evoke concepts and images that go against the grain of fundamental American values and ideals.

Individuals tend to personalize racism and oppression and cannot objectively view society and its institutions from such perspectives. Thus, there is a natural American tendency to dismiss racial differences or cultural variations as key factors to be addressed by American institutions and services. A major precept of the American value system is that an individual can overcome any condition, i.e., the old "pull oneself up by one's bootstraps" concept. The civil rights movement of the 1960s, many white Americans believe, took care of any and all racial/ethnic problems. The current resurgence of cries of institutional racism and cultural dominance create questions that have been buried and that are now met with increasing hostility and polarization. Often, there are concerns that cultural diversity is really a form of reverse discrimination, especially when the images of affirmative action, quotas, and preferential treatment are evoked ("The New Politics" 1991; Cox and Blake 1991).

Since change is so very frightening and difficult, it has been far easier to ignore cultural and ethnic diversity rather than confront it. And now, here it is at the front door again, more pressing and urgent than ever. For various reasons, American society is now at a point where it can no longer "stick its head in the sand" and hope that the issues will go away. There are many forces shaping the present focus on ethnicity and culture that require our nation to finally face the cultural imperative if we are to move into the 21st century in a continuing leadership position.

Factors Giving Rise to the Cultural Imperative

Shifting population demographics

Of course, the most obvious reason for the growing concern with ethnicity and cultural diversity is the changing demographics of the American population. According to the U.S. Census Bureau, over the last decade the number of Asian Americans more than doubled and the Latino/Hispanic population grew by more than 50 percent. "The new racial and ethnic figures . . . show that whites continue to decline as a proportion of the population, that Hispanics grew faster than demographers had predicted and that Asians and Hispanics had begun to fan out to every region of the country" (Vobejda 1991). According to the figures in Table One, the overall population of the United States grew by almost 10 percent between 1980 and 1990. However, the white population grew by only 6 percent and declined from 83 percent of the population in 1980 to 80 percent in 1990. On the other hand, all of the ethnic minority populations grew, with blacks registering the lowest percentage change (13.2 percent) and Asian/Pacific Islanders showing a percentage change of almost 108 percent.

TABLE ONE: THE CHANGING NATION

U.S. POPULATION BY RACE AND HISPANIC ORIGIN

	1980		1990			
	Number	Percent	Number	Percent	Number Change	Percent Change
Total U.S. Population	226,545,805	100.0	248,709,873	100.0	22,164,068	9.8
White	188,371,622	83.1	199,686,070	80.3	11,314,448	6.0
Black	26,495,025	11.7	29,986,060	12.1	3,491,035	13.2
American Indian, Eskimo, Aleutian	1,420,400	.6	1,959,234	.8	538,834	37.9
Asian/Pacific Islander	3,500,439	1.5	7,273,662	2.9	3,773,223	107.8
Other Race	6,758,319	3.0	9,804,847	3.9	3,046,528	45.1
Hispanic Origin	14,608,673	6.4	22,354,059	9.0	7,745,386	53.0

Note: Persons of Hispanic origin can be of any race. Source: Census Bureau; *The Washington Post*, 3/11/91.

Most of the increase among the Asian and Latino/Hispanic populations is due to immigration. In addition, high fertility rates play a large role in the growth of all four ethnic minority groups. Another reason for growth in the census numbers for Latino/Hispanic and American Indian groups appears to be increased identification with the ethnic designation than with the white designation in the census categories. There has also been an increase in the number of Americans who indicate they are of "other races." Often, persons in this category are biracial.

Not only is the increase in these populations shifting the demographics of the country, but more of the population in three of the four core ethnic groups tend to be younger than their white counterparts. For example, only a third of the white population is under 19 years of age. This percentage is also reflected in the Asian American group, although it should be noted that the heterogeneity within this category must be considered. For example, Japanese Americans have a low fertility rate, minimal immigration, and high rates of outmarriage. However, Chinese Americans, Filipino Americans and Southeast Asian Americans are now the predominant Asian American groups in the country and tend to be younger (Gibbs and Huang 1989).

Among the other three ethnic groups, however, the percentages of the population under 19 years of age are: African American (50 percent), Latino/Hispanic (45 percent), and Native American (40 percent). Therefore, children of color will make up an increasing portion of the country's young population. According to the Children's Defense Fund (1991), minority children

were 30 percent of the child population in 1990 and by the year 2000 will increase to 33 percent. These increases are expected to continue so that around the year 2020, minority children will increase to 40 percent of the child population in this country (p. 146). Nationwide, such figures have great significance for changes in school enrollment and the work force. Students of color are now the majority in the 25 largest public school systems in the country. Yet, ethnic minority youngsters, as stated earlier, are more likely to be poor, which is associated with high, school drop-out rates and other indicators that alarm businesses which face a slowdown of middle-class entrants and whites into the nation's labor pool. Businesses are already concerned about the implications for the continuation of a productive work force and profits that will be more dependent on culturally diverse groups than is presently the case (Cox and Blake 1991).

These demographic shifts indicate that there is a "darkening" of America, and the children of tomorrow will be increasingly black, brown, red, and yellow. Certainly these significant demographic shifts in population must be taken into account in planning for the future. As McLoyd (1990) summarizes:

> . . . minority children constitute a rapidly growing segment of the population on whose competence and productivity America will increasingly depend; hence, it is myopic, costly, and perilous to ignore the cultural, ecological, and structural forces that enhance and impede their development (p. 263).

Shifting to a world or global economy

Another trend leading to increased interest and attention on cultures and ethnicity is reflected in the notion that the world is shrinking, and American businesses will have to compete in a global marketplace rather than one that is focused entirely within this country. Not only is the potential work force within this country going to become increasingly dependent on ethnic minority groups, but as Europe moves closer to the implementation of its common market, and Japan and Germany continue to become increasingly competitive with the United States, American businesses have to assess their productivity and ability to compete inside as well as outside the United States. The availability of cheap labor forces, tax breaks, and other such factors will begin to determine the location and productivity of business sites and locations. And, it is anticipated that American companies will begin to establish more and more facilities outside of the country and/or cater to a world population rather than just an American one.

In order to be successful in these business undertakings, American businesses must understand the values and cultures of the countries in which they locate. Since 90 percent of the world's population is non-white, this suggests that ethnicity and differing cultures will become particularly important if productivity and profits are to be realized. As an illustration, recent comparisons of Japanese and American businesses suggest that they operate under very different value systems and cultural dictates, yet, the Japanese have proven to be extremely competitive. For example, in 1982, Citicorp led the world as the largest bank. Four of the top five banks were located in the United States and France. In 1990, all of the top five banks in the world were located in Japan (Lohr 1991). American businesses are beginning to assess the values and beliefs that have fueled them since the 19th century. The presumed superiority of the American

approach is being challenged and questioned. Rather, there is growing recognition that American businesses will have to adapt their approaches and routines to account for different cultural and ethnic practices and values.

Shifting the social integration and interaction paradigm

Since the massive immigration of white European groups into America during the 1930s and 1940s, the melting pot ideology of ethnic group relations has dominated theories about social integration and interaction among various ethnic groups in this country. This melting pot paradigm is predicated upon the critical concept of assimilation. According to the anthropologist, M. Herskovits (1938), assimilation can be viewed as an evolutionary stage in the social relations of a cultural system where people of different ethnic backgrounds had been in contact for prolonged periods of time. According to this perspective, "prolonged contact would eventually lead to the cultural fusion of both cultures or the homogenization of one culture in the direction of the other" (Menchaca 1989). Hence, the image of America as one big melting pot where all ethnic groups were thrown in, mixed up, and emerged to become something that was uniquely American. Consequently, if all ethnic groups eventually reached this homogenized American cultural status, then there would be no need to emphasize or treasure differences. Therefore, assimilation led easily to the notion of culture blindness or color blindness. This paradigm worked very well in explaining the experiences of white immigrant groups that voluntarily migrated to America to seek greater opportunities and a higher standard of living.

However, this particular paradigm does not accurately reflect the experiences of most of the ethnic groups of color that find themselves on American soil. The immigration experiences with the Euro American culture were very different for these groups. These differences included issues of inequality, power relations, severe economic conditions, and social isolation rather than social interaction. As Spencer (1990) notes, "'minority' in the United States does not merely connote membership in some group other than the majority. Some of the 'minority groups' in the United States are referred to by Ogbu as castelike – 'minorities incorporated into a society more or less involuntarily and permanently through slavery, conquest, and colonization'" (p. 268). African Americans involuntarily came to this country as slaves; Native Americans were massacred and placed on reservations in their own land. The immigration experiences and status of some Latino/Hispanic and Asian American groups could also be viewed as fitting into this type of minority status.

Even with prolonged contact, these inequities and social isolation continue. Therefore, the concept of assimilation has very different connotations when applied to ethnic minority groups. During the civil rights upheavals that marked the 1960s, it became clear that the melting pot ideology had clearly failed in its mission when it came to ethnic minority groups that were physically different from their Euro American counterparts. In 1964, Gordon argued that the melting pot ideology should be abandoned because no empirical evidence existed in its favor. He suggested that, both culturally and structurally, this ideology had been "an idealistic illusion exhibiting a naivete of the social ordering and structures of our society" (Menchaca 1989). Spencer (1990) also concluded that "the melting pot perspective hypothesized more than 20 years ago has not come to exist, and there is no reason to believe that such blending of ethnic groups

will take place (or, in fact, is desired) to any significant degree in the foreseeable future" (p. 269). The more compelling model that seems to best explain the relationship between ethnic minority groups and the Euro American mainstream is "Anglo-conformity" (Gordon 1964). Ethnic minority groups are becoming increasingly aware of the discrepancies between what America professes to be (a melting pot) and what it actually is (an Anglo-dominated culture).

Even those ethnic group members that strive hardest for assimilation into the dominant culture often find that its institutions and social structures still contain limitations based on skin color, physical characteristics, and inherent glass ceilings that ultimately limit opportunity and acceptance. For example, Asian Americans are often extolled as the model minority which has overcome racism and made it in American society through hard work, uncomplaining perseverance, and quiet accommodation. They are often used to illustrate the ability of the American social structure to accept and incorporate ethnically diverse persons. However, a number of Asian scholars have reviewed the beliefs upon which the model minority label is based and find that it is inaccurate, misleading, and a gross overgeneralization (Suzuki 1989). In fact:

> . . . Even for the more educated middle class Asians, the model minority stereotype remained problematic . . . as a group, Asians have *not* yet achieved full equality and participation in American society. The extant studies strongly suggest that Asians continue to face inequities in income and employment. Although many Asians are well educated and gain relatively easy access to entry-level jobs, they appear to encounter subtle discrimination when they attempt to move up the occupational hierarchy to managerial, administrative, or executive positions . . . they may encounter a racial barrier, the so-called "glass ceiling," as they try to move upward (pp. 14-16).

Shift in goal from assimilation to biculturalism

Since there is growing awareness that the melting pot ideology is a myth and that adherence to Anglo-dominance often does not produce the results (i.e., social integration and acceptance) that white immigrants experienced, many ethnic minority group members are redefining their goals vis-à-vis the dominant mainstream culture of America. Since assimilation for these groups often meant and means accepting negative stereotypes and beliefs about one's ethnic group (and, therefore, one's self), there has been increased understanding that denying the importance of ethnicity may create just as many problems. Although many argue that much of the discrimination and racism in American institutions and attitudes is directly related to socioeconomic status and not race (Wilson 1987), the example of Asian Americans cited above, as well as countless personal anecdotes among prominent African American and Latino/Hispanic professionals, tend to refute the notion that ethnicity has ceased to be a barrier to acceptance into the American mainstream. Nor is socioeconomic status always a buffer against the discrimination and racism often directed towards people of color by dominant society members.

Many are beginning to recognize that the practice of denigrating the cultures and achievements of people of color in American society is having a negative impact on their children. Spencer and Markstrom-Adams (1990) note that "throughout the nation over the last 200 years, the experiences of Hispanics, American Indians, and African Americans are consistent in one respect: The children of each group have been exposed to negative imagery and a nascent sense

of *invisibility* in school materials. A recent review suggests the absence may have implications for schooling and that it is important for minorities to internalize and maintain traditional values for maximizing educability beginning at the preschool level for both cultural and language-different minorities" (pp. 299-300). It should be noted that the Asian American community also reacts strongly and experiences the feeling of invisibility in educational materials for their youngsters as well.

The recognition of this invisibility and exclusion has been growing since the failure of the integration thrust of the 1960s and has resulted in a shift in ethnic minority groups towards the importance of biculturalism rather than assimilation as the appropriate and crucial identity pattern for children of color. The notion of biculturalism suggests the ability to function effectively and successfully in the American mainstream and yet maintain positive and significant cultural connections to the ethnic community if that is desired (Pinderhughes 1989). Biculturalism also includes the teaching of cultural values and traditions that may often conflict with those of the dominant mainstream culture. Therefore, ethnic identity becomes a major complicating factor for adolescents of color who must add this dimension to all the other identity issues experienced during this period. However, the formation of a positive and supportive ethnic identity seems to be an important criteria for successful interactions with the dominant culture (Spencer and Markstrom-Adams 1990). Harrison et al. (1990) found that a study of a national sample of African American three-generational families indicated that "the manner in which parents oriented their children toward racial barriers was a significant element in children's motivation, achievement, and prospects for upward mobility. Parents of successful children emphasized ethnic pride, self-development, awareness of racial barriers, and egalitarian values" (p. 355).

Adopting the concept of biculturalism rather than assimilation has led to cries of a return to "separate but equal" practices among white Americans and even some members of ethnic minority populations. They believe that the focus on cultural and ethnic differences reinforces and encourages segregation and separation. Given all of the civil rights activities dedicated to removal of Jim Crow laws and other separatist policies, especially in the South, the movement towards biculturalism on the part of people of color seems regressive and alarming. In a recent paper, Hanley (1991) explored the impact of the civil rights movement on the South and suggests that culturally competent programs have not developed as quickly there as in other regions of the country because the primary role of civil rights in the South was to achieve a state of "cultural blindness."

Often, those choosing to dissent from the concept of cultural competence cannot accept that the melting pot ideology has failed; color-blindness only leads to services and practices that do not address the real structural barriers and value differences that ethnic minorities encounter in American institutions. Such approaches lead to major frustration, disappointments, and anger for many children of color. Biculturalism and/or immersion in positive cultural values tend to produce children and adolescents of color that have higher self-esteem levels and greater confidence and competence (Gibbs and Huang 1989; Spencer and Markstrom-Adams 1990). It also serves to decrease the marginality and schizoid living style that often accompanies people of color as they become upwardly mobile in American society (Isaacs 1984).

Biculturalism also suggests that the goal of American society should be pluralism and multiculturalism, rather than Anglo-dominance disguised as the color-blind melting pot. The bicultural nature of the American experience for ethnic groups of color is constantly reinforced by external factors to which they are subjected – discrimination, racism, and powerlessness. In fact, through his review of the literature on assimilation, Menchaca (1989) observes that it is the very "practice of social segregation which has contributed to the maintenance and persistence of an ethnic identity among racial minorities" (p. 210).

Often, the cultural values and orientation of the ethnic group are different from those of the American mainstream society. As can be seen in Table Two, Elizabeth Randall-David (1989) identifies some of the differences in cultural values and orientations between Anglo-Americans and other ethnic/cultural groups. These differences suggest that children of color have to undergo a more complex socialization process than Euro American children. To deny the additional processes that must occur, through a color-blind approach to services and interventions, inflicts real injustice and harm in understanding both the psychological makeup and functioning of children and families of color.

TABLE TWO: COMPARISON OF COMMON VALUES

Anglo-American	Other Ethnocultural Groups
Mastery over nature	Harmony with nature
Personal control over the environment	Fate
Doing-activity	Being
Time dominates	Personal interaction dominates
Human equality	Hierarchy/rank/status
Individualism/privacy	Group welfare
Youth	Elders
Self-help	Birthright inheritance
Competition	Cooperation
Future orientation	Past or present orientation
Informality	Formality
Directness/openness/honesty	Indirectness/ritual/"face"
Practicality/efficiency	Idealism
Materialism	Spiritualism

ETHNICITY AND CHILD MENTAL HEALTH

At the same time that external forces and the growth of population and consciousness among ethnic minority groups is creating a wave of increased attention to ethnicity and culture, another major change is occurring in American society. There is increased recognition that the structures and practices established to address the needs of children and families in society are antiquated,

ineffective, costly, and only slightly beneficial to those they purport to help. In fact, the status of American children has deteriorated significantly as described by the Children's Defense Fund (1989) and Hewlett (1991). Although these reports indicate that the failure of institutions spreads across child welfare, health, juvenile justice, education, and substance abuse, the particular focus of this monograph is on child mental health services.

Since the publication of Jane Knitzer's (1982) groundbreaking report, *Unclaimed Children*, which found that mental health services for children with emotional disturbance were inadequate (fewer than 30 percent of children were receiving needed services), and inappropriate (when services were available they were usually in the most restrictive settings), there has been a movement towards greater attention to the mental health needs of children and a service system that reflects these needs. The establishment of the National Institute of Mental Health's Child and Adolescent Service System Program (CASSP) in 1984 gave impetus and thrust to a new philosophical approach to understanding and addressing child mental health problems. Under this program, states were encouraged to develop and implement a concept and vision of a system of care for children, adolescents, and their families.

CASSP is based on the philosophical paradigm that children and adolescents with serious emotional disturbance have multiagency needs and, that in order for them to have all of their needs met in an appropriate and effective manner, new systems of care and services approaches had to be developed. According to Stroul and Friedman (1986), the system of care paradigm is based on two core values and a set of principles to guide the delivery of services to children and families. The core values conceptualized in the system are that it be *child-centered and community-based*. It must be driven by the needs of the individual child and the child's family, and appropriate services should be provided in the least restrictive environment within or near the child's community. The concepts of individualized care and wrap-around services have become guiding principles for the new mental health paradigm for children. These concepts are based on an assessment of child and family needs and then delivering services directly related to those needs. Further, strengthening the participation and support of families as well as greater emphasis on multiagency coordination and cooperation are other principles that provide an impetus for major changes in child mental health.

Not surprisingly, the values and principles of the system of care for child mental health bring cultural values and ethnicity into greater prominence than was true when institutional settings were considered the major source of care. By focusing on the individual child, his/her family and their particular needs; by emphasizing community-based services; and by concentrating on the multiple problems and needs of children and families (i.e., multiple interventions by multiple agencies), the issues of values, culture, and ethnicity become extremely important. To individualize care for an American Indian child in his/her community (perhaps, a reservation) requires something very different than the individualized care that may be offered to a middle-class Euro American child in a suburban community.

In other words, the CASSP principles and philosophy suggest that children and families must be treated within their unique and specific context. This includes the child's intrinsic values, strengths and weaknesses, the child's particular family system, the child's particular relationship

within his community, and the child's relationship with the external or larger society. When mental health is viewed from this broader and more ecological approach, then the importance and saliency of culture and ethnicity cannot be overlooked. To do so means that important components of the child's and family's uniqueness are not being taken into account. Culture and ethnicity mean different things to different persons, even those within an ethnic minority group. The principles of the system of care suggest that it is important to understand what these do mean to the individual and family, rather than ignoring them because of a traditional color-blind approach to care.

This document contends that it is critical to explore what ethnicity and culture mean to a particular child and family, given the changes in American society as well as the historical relationship that ethnic groups have had with the dominant Euro American group. To ignore these factors is to provide inappropriate and insensitive services and interventions to ethnic minority children and their families. A major part of the equation that makes up the context in which children of color grow, develop, and learn is based on the relevancy and unmitigating importance of ethnicity in society.

Isaacs (1986) identified a number of the external stresses that impact upon and influence the emotional health and psychological development of ethnic minority children. These include the following:

- Racism and discrimination;
- Mass media and the way in which ethnic minority groups are portrayed;
- The strain of acculturation and the migration experience;
- Legal constraints and strategies for circumvention, such as issues on American Indian reservations or those associated with refugee status;
- Language and communication pattern differences;
- Socioeconomic status, especially since ethnic minority groups are disproportionately represented among those defined as living in poverty;
- The American economy and the availability of employment opportunities;
- Geographic isolation and resource-poor environments; such environments include urban inner cities, rural areas, reservations, barrios, and other enclaves in which people of color are isolated from the mainstream;
- Inter- and intra-group conflicts and tensions; and
- Assimilation and the loss of some of the most highly skilled/competent members of ethnic minority groups to the larger society (pp. 2-4).

Many of these factors have been found to place ethnic minority children at risk of an increased probability of mental disorders and emotional disturbance.

Ethnicity also influences the manner in which a child defines and understands himself and his world. Therefore, Gibbs and Huang (1989), in their discussion of ethnicity and mental health, note its importance as follows:

> First, ethnicity shapes the child's belief system about what constitutes mental health and mental illness, encompassing both general criteria and specific behaviors.
>
> Second, ethnicity influences the child's manifestation of symptoms, defensive styles, and patterns of coping with anxiety, depression, fear, guilt, and anger. Some ethnic groups reinforce "acting in" neurotic symptoms, others reward "acting out" characterological symptoms, and still others reward somatic symptoms. Children learn patterns of illness and dysfunctional behavior that are culturally reinforced and tolerated.
>
> Third, ethnicity largely determines help-seeking patterns that parents use to seek relief for children or adolescents with dysfunctional behaviors or symptoms. Parents may, for example, consult a priest or minister, a spiritualist or native healer, an herbalist or acupuncturist, or a tribal council or family elder.
>
> Fourth, ethnicity is a major factor shaping the way the child or adolescent utilizes and responds to treatment. Initial level of trust and openness, attitude toward self-disclosure, willingness to discuss certain topics, motivation to participate in insight-oriented treatment – all these aspects of the treatment relationship are filtered through the screen of ethnicity (pp. 8-9).

The critical and inherent importance of ethnicity and cultural values as a guiding force in reshaping service delivery has led to an additional principle to the CASSP system of care philosophy, namely, that the system of care must be culturally competent.

The Cultural Competence Approach/Model

In order to address cultural competence in child mental health delivery systems, Cross, Bazron, Dennis, and Isaacs (1989) developed the monograph entitled *Towards A Culturally Competent System of Care, Volume One*. In this document, the authors provided a philosophical framework and practical ideas for improving service delivery to children of color who suffer from emotional disturbances. The framework, or model, was that of cultural competence. The authors indicate that cultural competence involves systems, agencies, and practitioners with the capacity to respond to the unique needs of populations whose cultures are different than that which might be called "dominant" or "mainstream American (p. 3). The definition of cultural competence was explained as follows:

> The word culture is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function in a particular way: the capacity to function within the context of culturally-integrated patterns of human behavior as defined by the group (p. 3).

Thus, cultural competence was defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.

According to the authors, five essential elements contribute to a system's, institution's, or agency's ability to become more culturally competent. The culturally competent system would: (1) value diversity, (2) have the capacity for cultural self-assessment, (3) be conscious of the dynamics inherent when cultures interact, (4) have institutionalized cultural knowledge, and (5) have developed adaptations to service delivery reflecting an understanding of cultural diversity. Further, these five elements would be manifested at every level of an organization – policymaking, administrative, and practice levels – and would be reflected in its attitudes, structures, policies, and services.

In addition, the monograph outlined the major values and principles that should guide the development of culturally competent systems and services for children and families of color. These values and principles include the following:

- The family as defined by each culture is the primary system of support and preferred intervention.

- The system must recognize that minority populations have to be at least bicultural and that this status creates a unique set of mental health issues to which the system must be equipped to respond.

- Individuals and families make different choices based on cultural forces; these choices must be considered if services are to be helpful.

- Practice is driven in the system of care by culturally preferred choices, not by culturally blind or culturally free interventions.

- Inherent in cross-cultural interactions are dynamics that must be acknowledged, adjusted to, and accepted.

- The system must sanction and in some cases mandate the incorporation of cultural knowledge into practice and policymaking.

- Cultural competence involves determining a client's cultural location in order to apply the helping principle of "starting where the client is" and includes understanding the client's level of acculturation and assimilation.

- Cultural competence involves working in conjunction with natural, informal support, and helping networks within the minority community, e.g., neighborhoods, churches, spiritual leaders, and healers.

- Cultural competence extends the concept of self-determination to the community.

- Cultural competence seeks to match the needs and help-seeking behavior of the client population.

- An agency staffing pattern that reflects the makeup of the client population, adjusted for the degree of community need, helps ensure the delivery of effective services.

- Culturally competent services incorporate the concept of equal and non-discriminatory services, but go beyond that to include the concept of responsive services matched to the client population.

Finally, the monograph consistently cautions that cultural competence is a developmental process, and that it occurs along a continuum. The monograph identified six possibilities starting from one end of the continuum building towards the other, including: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, and cultural proficiency. At best, most of the human service agencies working with children and families fall between the cultural incapacity and cultural blindness spectrum of the continuum. It is very important for agencies to assess where they fall along the continuum before any effective planning for achieving higher levels of cultural competence can occur.

Since the publication of the first monograph on cultural competence, there has been much activity in the field of child mental health and within other child-serving agencies to begin to modify and create service delivery systems that are more culturally sensitive and that reflect the needs of various ethnic populations. As will be illustrated throughout the remainder of this monograph, cultural competence activities have taken many shapes and paths.

When addressing the issue of cultural competence, as with other complex frameworks, there is a tendency for practitioners and others to want a textbook solution – a "how to" or "cookbook recipe" approach that will lay out a step-by-step formula. Regretfully, the complexity of cultural competence does not allow for such a cookie-cutter solution. The remainder of this monograph will describe various programs that have attempted to further the concept of cultural competence in mental health and other child-delivery systems. Many different paths lead to cultural competence. Whichever path is chosen has to be tailored to the particular needs and characteristics of the ethnic groups, the community, the service organizations, the attitudes and philosophies of policymakers, and the political, economic, and social circumstances that shape interactions in a given area or community. It should also be evident that the development of culturally competent programs is in the most rudimentary of stages and there is much room for further creativity and accomplishment.

CHAPTER II

CROSS-CUTTING ISSUES IN MOVING TOWARDS CULTURAL COMPETENCE: LESSONS LEARNED FROM PROGRAM SITES

Whenever the issue of cultural competence arises in the field of mental health, one is confronted with the impression that professionals are overwhelmed and do not know where to turn for information or guidance. Yet, there has been a substantial body of literature over the last 20 years that has addressed the importance of ethnicity and culture in mental health practice and outcomes. Most of this literature is, however, theoretical in nature. While many of the concepts and principles have yet to be empirically tested, there appear to be certain assumptions and observations that are universally held and that should be used to guide the development of mental health policies, programs, and services for ethnic minority groups (Neighbors, et al. in press).

An overriding notion is that if the goal of mental health services is to raise the level of mental wellness for all individuals and communities served, then, as Lefley (1986) asserts, "attainment of this goal involves an accepted conceptual method of defining psychopathology, consensus on appropriate preventive measures, accurate diagnoses of emotional disorders, and, when indicated, selection of effective therapeutic interventions" (p. 11). Therefore, if this goal is to be reached, there must be congruity between the world views of the clinician or agency and the population to be served.

To move further towards culturally competent systems of care, at least six questions or issues should be addressed by mental health policymakers/practitioners as well as by other human service providers who are confronted with large numbers of ethnic minority persons in their client population pool.

Questions Addressed

Question 1: How and by whom is mental health and illness being defined?

The definitions of mental health and mental illness are very important in developing services for ethnic minority populations. As exemplified through the use of the DSM-III-R (1987) diagnostic classification scheme, traditional western definitions focus on inherent personality, genetic, or biological differences within the individual. None of the current diagnostic classifications address the impact of race, ethnicity, or culture on the manifestation of symptoms and behaviors that suggest emotional difficulties. Yet, the DSM-III-R is widely used by practitioners, and providers must often use a diagnosis from this classification system to obtain payment for services. It should not be a surprise, therefore, when ethnic minority populations disproportionately receive the more severe and less retractable diagnoses under the DSM-III-R system.

Ethnic minority mental health professionals, as well as a growing body of literature, indicate a basic belief that many of the psychological and emotional difficulties experienced by ethnic minorities stem from social and environmental stressors. Therefore, they argue, the definition of mental health must be broader, not only including intrinsic personality characteristics, but also such areas as the impact of discrimination, poor housing, poor education, poverty, lack of employment, and social isolation on the functioning of members of ethnic minority groups. Many researchers believe that mental health intervention strategies in minority communities must focus on multiple levels: the individual, family, ethnic community, and mainstream institutions and practices.

Question 2: What are the factors that should be assessed to determine whether there is a mental health problem and exactly what that problem is?

The question of assessment is a very big one when it comes to mental health and ethnic minority populations. As noted earlier, there has been a considerable body of literature that suggests that traditional assessment instruments and psychological tests often lead to misdiagnosis of ethnic minority group members, often indicating that they have more severe psychiatric diagnoses and problems. For example, Gynther (1972) has found that blacks show differential profiles on the Minnesota Multiphasic Personality Inventory (MMPI) and has indicated that the normative differences are large enough to result in misdiagnosis of a significant proportion of black respondents as psychotic. In a factor analysis of the MMPI performed on normal black populations, it was observed that the pattern of black subjects which peak differentially on the psychotic scales may be a cultural artifact. Similar findings utilizing psychological testing in children and adolescents suggest that instruments normed on white, middle-class populations often portend high levels of deviance or pathology when applied to ethnic minority populations. As Lefley (1986) concludes, "there is considerable evidence that, lacking normative data on non-psychiatric community populations, the scores of non-white, non-English speaking patients on diagnostic screening instruments may be of dubious validity, and in some cases, seriously misleading" (p. 12).

Another major concern in the whole assessment process is ensuring that salient issues are included. Many studies indicate that traditional assessments fail to address a lot of the issues that are critical to the psychological makeup of ethnic minority groups and do not measure the potential strengths and adaptive mechanisms of the person of color. For example, ethnic identity is a critical identity issue for ethnic minority children and adolescents. Yet, few traditional assessment and screening instruments or psychiatric evaluation interviews measure the level of ethnic identification. Ethnic identity, in and of itself, is a complex construct that has important ramifications for successful functioning. Bernal et al. (1990) and Ruiz (1990), through studies of Latino/Hispanic children, contend that there are stages of ethnic identity and that it is important to understand which stage a particular child or adolescent has reached in the ethnic development process.

According to McGoldrick, Pearce, and Giordano (1982), other factors that should be included in an appropriate assessment of ethnic minority families include: the level of acculturation and assimilation; the migration experience; the language spoken in the home; race

and country of origin; family's place of residence (e.g., whether or not they live in an ethnic neighborhood); socioeconomic status, educational achievement, and upward mobility of family members; the emotional process in the family; the political and religious ties to the ethnic group; the family life cycle; values orientations; and strengths and positive coping strategies. For assessments involving children and adolescents, it is also important to understand the child-rearing practices and values of the family.

Such practices vary widely within and among cultures. For example, in a comparative study of child-rearing practices of Chinese, immigrant Chinese, and Euro American parents, Lin and Fu (1990) found that: (1) Chinese parents tend to control their children more than Euro American parents; (2) Chinese parents tend to be less expressive of their affection than Euro American parents; (3) Chinese parents are less likely to encourage independence than Euro American parents; and (4) Chinese parents emphasize the value of academic achievement more than Euro American parents. Collectivism and group identification also contribute to a child's achievement, that is, they are a reflection of the entire family or community. In conclusion, the authors state that attention to cross-cultural child-rearing practices needs to "take into account the traditional values and attitudes particular to each of the groups under investigation, as well as the external and structural environments in which they currently reside" (pp. 432-433).

Since there are so many variations in cultural norms, values, behaviors, customs, and experiences, mental health assessment processes must take these differences into account. There have been far too many times when cultural practices or language barriers have resulted in unnecessary psychiatric hospitalization or other restrictive placements for people of color. Therefore, it is critical that our assessment tools and instruments be sensitive and effective in identifying cultural issues and differences.

Question 3: How are mental health services offered and made accessible to the ethnic minority population?

One of the most consistent findings in the research literature is that ethnic minority groups underutilize or prematurely terminate mental health services (Neighbors et al. in press). Too often, ethnic minority groups are blamed for not properly utilizing mental health services. Little attention is paid to the biased referral processes whereby African Americans and other ethnic minority groups are more likely to end up in the juvenile justice or correctional system than the mental health system. Nor has sufficient attention been focused on the cultural factors that may play a role in underutilization or premature termination. Why does underutilization and premature termination occur and what can we, as mental health professionals, contribute to more appropriate referral patterns and outcomes? How can mental health services become more accessible and responsive to the needs of ethnic minority populations? Geographic location of services, hours of operation, and community perception of the facility's function are important considerations for increasing access and use of mental health services by ethnic minority groups. Understanding these groups' communication and information acquisition mechanisms can also promote increased access and use.

In a paper on treatment system considerations in the organization of mental health services for Asian and Pacific American communities, Herbert Z. Wong (1980) suggested that mental health and other health and social service programs which appeared to promote access and higher utilization by these groups had several similar characteristics. Among the most important with the most generalizability across the four major ethnic minority groups are:

- Community-based perspective – Programs are community based and usually have strong linkages, positive credibility, and good reputations with the ethnic minority community and its networks. Although these services may be affiliated with a major institution, they tend to be freestanding and physically located in or near the particular ethnic minority community.

- Longitudinal and developmental perspective – Both the program (or agency) and a portion of the personnel have been and continue to be providers in the particular community. Programs and individuals have positive track records. Commitment of individuals and groups for the program or service is moderate to high.

- Outreach orientation – The agency does not limit itself to the perspective that clients must be on site to receive services. Rather, services are provided, within cost constraints and clinical appropriateness, in the home or in more familiar settings like churches, schools, and community centers.

- Critical mass – Both a sufficient number of ethnic staff and of clients served appear to be necessary for a successful program. Programs that merely add a minority specialist do not appear to have as much impact. Cultural competence must also be represented in the administrative and managerial staff of the agency.

- Indirect benefits viewpoint – Direct clinical services appear to be enhanced when programs and agencies also offer some preventive and indirect services (e.g., consultation, mental health education and information, community organization, and program technical assistance).

These, as well as other factors, tend to change the perception of mental health services in ethnic minority communities. This change creates an atmosphere that encourages more positive interactions between the community and the program and, thus, increases ethnic minorities' access to services.

Often, these factors have led to the development and establishment of ethnic-specific programs and site locations. As noted in the previous cultural competence monograph, there are a number of ways to increase access, availability, and acceptance of mental health services among ethnic minority groups. There are several service models, but four models frequently appear: mainstream agencies providing outreach services to minorities, mainstream agencies supporting services by minorities within minority communities, agencies providing bilingual/bicultural services, and minority-owned agencies providing services to minority people. Three of the four models base services on emphasizing cultural values and helping systems. These services seem to have

a higher rate of satisfaction than those in the fourth model. However, there is some concern about the "separatist" nature of such services which tend to make ethnic-specific programs somewhat controversial with majority professionals and even among some professionals of color.

Question 4: What methods/interventions are chosen to ameliorate and solve mental health problems?

The methods or interventions utilized to address mental health problems depend upon the understanding that one has of their causes and consequences. Too often, insight-oriented psychotherapy is considered the therapy of choice by those trained in traditional mental health disciplines. However, recent reviews of the most frequent diagnoses of children and adolescents (which tend more towards behavioral and learning disorders) indicate that these disorders appear to be more amenable to structured behavior modification techniques and cognitive learning tools. In addition, certain types of methods and interventions tend to show more positive and effective results with ethnic minority populations. These include: recognition of and intervention in social problems, group therapy, family-focused therapies, in-home services, crisis intervention and problem-solving services, case management and brokering services, didactic and educational approaches, community-level interventions, and appreciation and recognition of cultural issues or problems. Although there has been no substantive research about the effectiveness of these approaches and methods for ethnic minority populations, anecdotal information and individual program data suggest that these are deserving of further consideration and utilization.

Moreover, there is considerable discussion in the published literature about the importance of identifying and utilizing the positive strengths and adaptive mechanisms inherent in the successful development of a bicultural frame of reference among ethnic minority group members. It is suggested that much can be learned about the strengths and positive adaptive skills of those members of ethnic groups who are able to effectively negotiate the mainstream culture while still remaining positively ensconced in traditional ethnic cultures. However, few studies have been conducted that either identify or incorporate such constructs in their intervention approaches.

Finally, the whole issue of initial engagement of ethnic minority families is critical since the first contact with the agency usually sets the tone for further interaction with mental health services. Studies have shown that many ethnic minority clients drop out of mental health services after one contact. Therefore, it is important to pay attention to how one goes about engaging the ethnic minority client in the treatment process. For example, in their attempts to engage Cuban adolescent drug abusers and their families, Szapocznik et al. (1990) developed the strategic structural systems engagement approach. Although this approach cannot be explained in great detail in this document, the strategic structural systems engagement was designed around knowledge about resistance to treatment in these families. In an experimental design, the researchers developed the engagement-as-usual condition and the structural systems engagement condition. Results indicated that the structural systems engagement condition was significantly more effective in increasing Cuban families' entry and retention in treatment.

Question 5: Who should administer/provide the intervention?

One of the most intense debates in the cultural competence domain revolves around the issue of staffing for programs and services. Some studies have indicated that the higher the number of staff from the minority group, the higher the rate of utilization of services by ethnic minority groups (Wu and Windle 1980; Snowden, Storey, and Clancy 1989). Although ideally the staffing should reflect the cultural makeup and diversity of the client population, more often than not this does not occur. A portion of this staffing dilemma has to do with problems with and the lack of creativity around identifying, recruiting, and retaining minority professionals.

Much of this problem also arises from the scarcity of ethnic minority professionals in the mental health professions. In 1989, out of 68,320 members in the American Psychological Association, 91 were identified as American Indian, 609 identified themselves as Asian, 824 identified themselves as Latino/Hispanic, and 849 identified themselves as African American (1989 APA Directory). Although a rather large percentage of the membership did not provide ethnic identification (33 percent) and some ethnic group members may not elect to be members of this professional organization, it is disheartening to see that ethnic minority professionals number just a little over 3 percent of psychologists in this country.

There appears to be more cultural diversity among the membership of the American Psychiatric Association (APA). Of the 50,896 psychiatrists included in a recent membership review (APA 1991), 36 were American Indian, 195 were Mexican American, 346 were Puerto Rican, 1,032 were Asian-Filipino, 1,100 were Asian-Oriental, and 1,147 were African American. These numbers represent a little under 8 percent of psychiatrists in this country. In addition, another 1,763 identify themselves as being of Spanish descent and an additional 2,534 are Asian-Indian. If these groups are added, the percentage of ethnic psychiatrists rises to almost 16 percent. Even though nursing and social work may contain higher percentages of ethnic minority professionals, it is clear that, at these rates, and with decreasing ethnic minority enrollments in graduate school programs, there will not be an adequate supply of ethnic minority professionals to provide all the services needed.

Two predominant approaches have been advanced for resolving the staffing dilemmas for culturally competent programs and systems. Neither of these is meant to eradicate the critical need to increase enrollments in mental health and related disciplines in our higher education institutions. Rather, they are a pragmatic and practical solution to the realization that, until such time, if ever, there is an adequate supply of ethnic minority professionals, then supplemental approaches must be considered.

One approach is to utilize paraprofessionals. This was a very common practice in the early periods of the community mental health movement, especially for those centers that were located in or served large numbers of ethnic minority clients. However, depending on the way in which paraprofessionals were used, there tended to be concerns about whether clients were receiving appropriate care and about the unequal relationships between paraprofessionals and professionals. The question arose as to whether these inequities were just another form of discrimination for ethnic minority clients in the mental health system.

Since that time, a number of approaches have enhanced the skills of paraprofessionals and have reduced some of the concerns about their use. First of all, paraprofessionals are now not considered to be substitutes or equivalents of professional therapists and practitioners. Their roles and responsibilities are clearly and distinctly defined. Secondly, the identification and use of paraprofessionals is now viewed as another route to obtaining more trained ethnic minority professionals rather than just a goal in itself. There are expectations that paraprofessionals will be able to advance their skills and careers (through built-in career ladders) and, in many instances, this includes attainment of some type of appropriate human services degree. Consequently, the way that paraprofessionals are utilized and the incentives provided by the program for further advancement are critical concerns.

No matter how innovative paraprofessional training programs are, there is agreement that the most effective approach to developing a culturally competent work force is to train majority staff to understand and work more effectively with different ethnic minority populations. Ideally, such training should be received in undergraduate or graduate programs. However, few professional training programs provide adequate courses or practice experiences to prepare students to work cross-culturally in a competent manner. Therefore, it is important that programs offer such training to their staff through inservice courses and/or intensive training workshops. As Pedersen and Lefley (1986) note: "Adequately trained mental health professionals will have an *awareness* of their own cultural biases, *knowledge* about the research literature relating culture to mental health, and *skills* to implement the insights resulting from knowledge and awareness in a culturally appropriate format . . . The goal of cross-cultural training is to increase a counselor's intentionality through increasing the person's purposive control over the assumptions which guide his or her behavior, attitudes, and insights" (p. 5).

The literature and research supports the need for ongoing and concentrated training of mental health professionals in development of cultural competency. However, for the most part, such training is not available in institutions of higher learning, and curricula need to be developed or modified to address this shortcoming.

Question 6: What are the expected or anticipated outcomes? How can client progress, treatment, and program effectiveness be measured?

In the field of mental health, there has always been some concern about measuring client outcomes and the effectiveness of treatment approaches and programs. In addition, there is a real need to identify outcomes that can be easily defined and measured. In the area of delivery of culturally competent services, there is very little research. There has been no systematic attempt to identify the factors or components of programs that enhance cultural competence, and there have been very few attempts to review or measure outcomes for clients served in ethnic-specific programs. However, there is some preliminary evidence through studies of ethnic matching between clients and therapists that utilization and length of stay in treatment are higher when clients are matched with ethnically similar therapists (Snowden, Storey, and Clancy 1989). There is also increasing evidence that culturally tailored programs are effective in reaching and engaging hard-to-reach ethnic minority populations (Neighbors 1990). For example, Bobo et al. (1988) reported on the positive effects of the Indian Drug Prevention Program (IDPP) in

reducing adolescent substance abuse. The most important result, they found, was the wide acceptance of this program among traditional tribal members. The Miami Community Mental Health Program has also been recognized as a very effective program in serving ethnic minority populations in Miami, Florida. Through a number of culturally homogeneous miniclinics, the Miami staff is able to effectively deliver mental health services to Cubans, Puerto Ricans, Bahamians, and Haitians in the area (Neighbors et al. in press).

Lessons from Program Sites

The 11 programs selected for inclusion in this monograph illustrate how culturally competent principles can be operationalized to better serve children of color and their families. All of the programs strive to answer the critical issues about definitions of mental health, appropriate assessment, design of program interventions and goals, development of appropriate staffing patterns, and measures of successful outcomes for clients. Although these are addressed in many different ways by these programs, there are certain cross-cutting issues and characteristics that are inherent in the programs presented in the remainder of this monograph. Therefore, there are certain lessons gained from a holistic view of these programs that may prove to be of assistance to those who are attempting to develop or redesign programs for increasing numbers of ethnic minority groups in their population. There appear to be key elements and ingredients that mark programs striving towards greater cultural competency and effectiveness in serving children and families of color. These key elements and ingredients are discussed below.

1. Importance of Program Auspices

The programs selected for inclusion in this monograph represent the models discussed in the first volume of this series. Four are mainstream agencies which support services provided by minorities within minority communities – Santa Clara County Mental Health Bureau, Roberto Clemente Family Guidance Center, Roybal Family Mental Health Services, and the Yakima Indian Reservation Mental Health/Social Service Program. Four represent agencies providing bilingual/bicultural service – Santa Clara County Mental Health Bureau, Ada S. McKinley Community Services, Asian/Pacific Center for Human Development, and Three Rivers Youth. Five programs are minority-operated agencies providing services to minority populations – Progressive Life Center, Black Family Development, South Cove Community Health Center, Asian/Pacific Center for Human Development, and The Indian Health Board of Minneapolis. These programs are organized in a manner that allows them to be responsive to the cultural needs of the populations served.

There are two outstanding attributes or characteristics of these programs that may have had some impact on their ability to develop programs that move closer to culturally competent services. Both Three Rivers Youth and Ada S. McKinley serve a combination of majority, African American, and Latino/Hispanic populations. Santa Clara, as the county mental health agency, serves Asian Americans, African Americans, and Hispanics/Latinos in both bicultural/bilingual programs as well as ethnic-specific programs. With the exceptions of Santa Clara, Three Rivers Youth, and Ada S. McKinley Community Services, all of the remaining programs focus attention on one major cultural/ethnic group, although the recognition of

heterogeneity within these groups is a dominant factor. Thus, Progressive Life and Black Family Development focus on African American clients, Asian/Pacific Center for Human Development and South Cove focus on different Asian American and Asian refugee populations, Yakima and The Indian Health Board of Minneapolis specifically address American Indians of varying tribes, and Roybal Family Mental Health Services and Roberto Clemente Family Guidance address Latino/Hispanic cultural groups. These programs tend to address one specific ethnic group rather than providing services across the range of ethnic groups. Perhaps, this has to do with funding mechanisms or with the segregation of communities, but since it is an overriding characteristic of the selected programs, it should be noted. In addition, the organization of these programs tends to support the notion that being a member of an ethnic minority group in the United States does not necessarily prepare one to offer services to all other ethnic populations.

The second overriding characteristic that seems to mark the selected programs is that most of them (seven) operate as private, non-profit entities. Four – Santa Clara, Roybal, Yakima, and Roberto Clemente – operate as governmental service agencies. Although almost all of these programs are very dependent on federal, state, or local government sources for funding, the fact that most operate as non-profits tends to increase their flexibility and ability to adapt their services towards more culturally appropriate interventions and culturally competent policies and philosophies. The auspices under which the program is established and its ability to design and develop services that are more culturally competent appear to have some relation with non-profit status and focus on specific ethnic populations rather than generic minority programs.

2. Clear Program Philosophy and Policies

The more clearly articulated the program philosophy and policies based on cultural dynamics and inclusion are, the more culturally competent the programs tend to be. Therefore, programs such as Black Family Development and Progressive Life Center, which build on an Afrocentric philosophy and values, tend to focus on the strengths and attributes of African Americans throughout the entire treatment process. The philosophy affects how mental health is defined, how and what treatments are delivered, and how successful outcomes are identified. For instance, Afrocentrism, in contrast to Euro American culture, stresses "collectivism, cooperation, symbolism, traditional African religions and spiritualism, affective interactions over cognitive understanding, a relational mode of thought, the integration of time and space, and diunital logic" (Jackson 1986). This philosophy creates a different staffing and organizational structure, as well as the use of different treatment modalities in these programs.

The Indian Health Board's Soaring Eagles Program is predicated on teaching Native American youngsters their cultural heritage and values. The philosophical underpinning is that incorporation of Indian values will improve the mental health and self-esteem of Indian children and provide the core for successful development and productivity. Therefore, whichever treatment models are engaged in, they should be those which empower clients to see themselves within the context of their birthrights, history, and perceptions of reality. Such models often include a major spirit-oriented approach.

Programs, such as those exemplified by the Roberto Clemente Center, have philosophies that build upon the experiences and values of Latino/Hispanic groups who often have a migratory experience and strong family values that differ from those of the mainstream culture. Thus, the focus of mental health services must include an acknowledgement of these experiences as well as building on the strength and importance of family in Latino/Hispanic cultures. Most of the programs selected for inclusion in the monograph have clearly articulated philosophies based on the cultural values, strengths, and needs of their client populations.

3. Name and Location of Programs

Given the strong cultural underpinnings of the programs included in this monograph, it is not surprising that program operations and services are affected. Firstly, almost all the programs are community based and very accessible to the target populations. Many of these programs are co-located with health clinics or other settings that reduce the stigma associated with receiving mental health services. This is especially true for those programs serving Asians, Latinos/Hispanics, and American Indians. Five of the 11 programs are co-located within health settings, creating mental health and social services that are more accessible and acceptable to ethnic minority populations. Several of the programs also have school-based locations or offer services on site at schools. For those programs serving large numbers of African American clients, in-home or home-based services appear to be important in enhancing acceptability and accessibility to services. In any case, none of these programs is a freestanding, clearly identifiable, mental health effort.

The names of programs also play a role in helping to minimize the stigma attached to mental health services for ethnic minority populations. With few exceptions, the term "mental health" is not included in the name of any of the featured programs. Sometimes, programs are named after prominent community members or leaders (e.g., Roberto Clemente, Roybal); others emphasize positive concepts rather than deficits (e.g., Progressive Life, Soaring Eagles, Black Family Development). Although a seemingly small change, the impressions created by the naming of services are very important for ethnic minority groups.

4. Shift in Types of Services Offered

The services offered by these programs are not unique in and of themselves, however, the amount of emphasis on certain types of interventions and modalities does tend to differ from traditional programs. Although intensive insight-oriented talking therapy is available in these programs, most of the emphasis in many of the programs is on family therapy and group modalities. These modalities tend to combine both didactic or educational components, as well as exploration of feelings and behaviors. The emphasis on relational and interactive processes inherent in these modalities reinforces the importance of family and relationships in all of these ethnic cultures. The fact that these modalities also decrease the scapegoating of individuals and emphasize group support also seems to increase their effectiveness with ethnic minority populations.

In addition, therapies that are more focused on the here-and-now, as well as more behaviorally oriented and interactive, also seem to work well, especially for ethnic minority adolescents. Role-playing, hypnotherapy, visualization, and activity-related counseling seem to be effective in identifying and bringing out emotional issues in ethnic minority populations. These indirect approaches to gaining knowledge tend to minimize the resistance and resentment felt by those who view them as "prying and asking personal questions," which is often the perception and experience associated with individual psychotherapy.

As noted earlier, the emphasis on in-home services or outreach tends to empower ethnic minority clients. When mental health services are delivered on ethnic minority turf, the unequal power dynamics inherent in office-based, therapist/client relationships is diminished. When persons receive services in less stigmatizing and more natural community settings, closer partnerships and empowering opportunities are maximized.

Services and activities that have come to be associated with case management are also critical in serving ethnic minority populations. Often families encounter multiple problems across numerous systems. They frequently experience the frustrations of red tape and bureaucracy, in addition to systems that are culturally insensitive and discriminatory. Therefore, the availability of persons to assist in negotiating systems, and in providing concrete services and support on several levels, is extremely important in developing the relationship and maintaining the family or client in treatment.

5. Emphasis on the Importance of Family

All four of the ethnic minority groups which are the focus of this monograph share one clear, dominant characteristic – that is the importance of family. However, the family systems do not often meet the criteria associated with the typical middle-class, Euro American family. For example, Carolyn Attneave (1982) notes that the "traditional pattern of Indian family organization is quite different, with three generations involved and multiple parental functions delegated among aunts and uncles as well as grandparents. Cousins were all considered siblings, and incest taboos applied to all" (p. 72). Hines and Boyd-Franklin (1982) suggest that black families descend from "the heritage of shared loyalty and strong kinship bonds . . . Reliance on a kinship network, not necessarily drawn along 'blood' lines, remains a major mode for coping with the pressures of an oppressive society. Many have pointed to the number of uncles, aunts, big mamas, boyfriends, older sisters and brothers, deacons, preachers, and others who operate in and out of the Black home" (p. 87).

Sandoval and De La Roza (1986) specify the importance of family for Latinos/Hispanics when they state that "Hispanics, regardless of their national, racial, and social background, have in common a very strong family orientation. This overrides the importance of loyalty to, and participation in, other institutions most cherished by white Americans, such as the community, schools, churches, and clubs. The Hispanic family is an expanded network reaching out to relatives, in-laws and 'friends of the family,' involving its members in mutually supportive relationships of interdependence. This extended family offers its members economic and emotional support and enculturation assistance" (p. 154).

Finally, Root, Ho, and Sue (1986) indicate that "traditional Asians place great emphasis on the family and behave in accordance to their roles and statuses within the community. The emphasis on the family among Asian groups may be misinterpreted as overly dependent from a western conceptualization which views independence from the family of origin as the appropriate behavioral pattern . . . For example, traditional western therapy often strives for individualism as an implicit goal of therapy. This goal, however, is likely to be counterproductive with many Asian clients because it is in direct opposition to the cultural priority that stresses family over individual rights" (pp. 200-201).

Without exception, the programs included in this monograph view the family as the primary source of intervention; consequently, an understanding of the family is key to effective therapeutic interventions. This means that "family" must be defined by the client and often includes those who are not traditionally viewed as a part of family systems by Euro American standards. In addition, these programs build on the understanding that family structures vary considerably. Often, one of the major goals of therapy is to rebuild and maintain the extended support network that has been a source of strength for ethnic minority families but which has eroded in recent years. Many of the programs also focus on family assessments rather than individual assessments in determining appropriate interventions. A thorough understanding of the roles played by various family members as well as an articulation of the family values (especially as they relate to child-rearing practices) are critical components of the assessment process.

Nobles (1991) notes that the concept of family in ethnic minority groups appears to be based more on "eldership" than "parents." In American culture, when family is conceptualized, it is based on the parents having ultimate authority over the child. In ethnic minority cultures, families tend to be built around eldership so that even when parents are present, the ultimate authority may reside with a grandmother, an elder uncle, or others recognized by the family as having the greatest wisdom and respect. These differences in the importance and meaning of family, therefore, must be taken into account when assessing and developing effective treatment models for ethnic minority populations. Many of the selected programs illustrate how this cultural competence principle can be achieved.

6. The Need for Cultural Assessments

Almost all the programs recognize the need for cultural assessments of families and clients. However, since there are no cultural assessment instruments available that are considered reliable or valid, these programs often rely on their own forms and observations/responses gleaned from interviews. Each of the programs recognizes the importance of understanding where the family or client fits on a cultural continuum and attempts to determine this point on the continuum so as to better tailor services and therapist assignments. It is also important to conduct a cultural assessment so that differentiations can be made between socioeconomic conditions and cultural values. Finally, cultural assessments are often utilized to focus on strengths rather than deficits and to develop therapeutic interventions based on these strengths.

The lack of uniform, reliable, and valid cultural assessment instruments tends to be one of the overall weaknesses in the field at this time. Since cultural assessment is so critical, and since

so many of those providing services are from the majority culture, the pressure to develop valid and reliable cultural assessment instruments is expected to increase.

Bloch (1983) and others have identified a number of the variables and factors that should be addressed in a cultural assessment. These include: level of ethnic identity; values orientation; migration experience; current socioeconomic status and views about the role that ethnicity plays; habits, customs, and beliefs that are important to client; cultural health beliefs and practices; use of informal network and supportive institutions in the ethnic/cultural community; language and communication process; self-concept and self-esteem; views and concerns about discrimination and institutional racism; educational level and employment experiences; importance and impact associated with physical characteristics; and influence of religion/spirituality on the belief system and behavior patterns.

It should be noted that cultural assessments are also being developed so that individual practitioners as well as agencies can determine their level of cultural competence and create training opportunities and other program policies that will allow them to progress along the cultural competence continuum. Mason (1989) and others are in the process of attempting to validate these primarily self-assessment instruments focused on individual practitioners and mental health agencies. This work recognizes that cultural assessments are important at every level of a treatment organization. It is not enough to merely assess the cultural levels of clients, and, then, continue to have them treated by culturally insensitive staff or come to agencies with culturally insensitive policies and practices.

7. Ethnic-Specific Staffing Patterns and Recruitment/Retention Strategies

Staff who reflect the ethnic makeup of the population are one of the greatest strengths of many of the programs included in this monograph. From their boards, to administrators, to direct services and support staff, these programs have shown the ability to recruit and retain staff reflecting the ethnic makeup of their client population. This is remarkable given that the major problem that majority agencies encounter is the inability to find or retain competent ethnic minority staff.

The ability of these programs to recruit and retain ethnic minority staff seems to be related to several factors:

- The perception of the agency as a minority-oriented one with strong ties to the minority community. Many ethnic minority professionals have a strong commitment and dedication to "returning something to the community"; thus, many are drawn to agencies that provide an opportunity to do so through services or other types of community involvement.

- The use of formal and informal networks and resources indigenous to the minority community for recruitment purposes. For example, few of the included programs relied on advertisements in newspapers for recruitment of ethnic minority professionals.

- The ability to provide an ethnic support network and to demonstrate visible role models for career mobility and advancement. Such factors seem to enhance the retention of ethnic minority staff and many of these programs have very low turnover rates.

- The use and reputation of the program as a training site for students and young professionals who are seeking expertise in meeting the needs of various ethnic minority populations. Several of the programs provide internships and training placements for graduate students. These students often stay on to become members of the staff.

- The creative use of paraprofessionals. In those programs that utilized paraprofessionals, these staff were viewed in a developmental manner, and being a paraprofessional was not the end goal. Rather, career ladders and opportunities for paraprofessionals were built into the program; their development and training came from a real commitment to the goal of professional status for them. The types of paraprofessionals were also diverse, often including the use of undergraduate college students (Soaring Eagles) or indigenous natural helpers.

- The creative use of consultants and other scarce resources. It should be noted that many of these programs did not have staffing patterns that reflect the traditional medical model approach. Consequently, psychiatrists are not heavily represented in their staffing patterns. However, the programs often utilized psychiatrists, other professionals, and natural helpers as consultants when there were specific problems or issues related to particular clients.

Although individual programs have very different staffing patterns, there appears to be one critical principle that assists in the recruitment and retention of ethnic minority staff – namely, that there is a need for a critical mass of ethnic minority staff and programs must have such staff to be successful in recruiting and retaining them. Thus, many majority agencies are caught in a chicken or egg situation. Further, it appears that the critical mass is always more than one ethnic minority professional. Tokenism seems to work against the agency and against the retention of the ethnic staff member who has to become everything to everybody.

8. Training, Education, and Curriculum Development

Another strength of many of the programs included in this monograph is the strong emphasis and importance placed on training. Although many of them are staffed by ethnic minority professionals, there is recognition that these professionals are almost always trained in traditional Euro American graduate schools. Therefore, in nearly every situation, there is a need to retrain them to work in agencies striving to become more culturally competent.

In the orientation of new staff and training opportunities for seasoned staff, many of these programs provide ongoing, intensive, inservice training. Cultural issues are addressed and incorporated in every aspect of the agency's functions and policies, thus creating a cultural milieu for staff as well as clients. Many of these agencies have developed formal curricula (such as the

Roberto Clemente Center and Black Family Development) or formal training institutes (such as the Progressive Life Center).

In addition to an emphasis on training for their own staff, many of these programs offer training to other community agencies and government organizations. Thus, many are well-known for their training capabilities and skills in meeting the needs of culturally diverse clients and groups. Many also provide consultations to hospitals, courts, police, health centers, schools, and other organizations experiencing problems in understanding the cultural components of behavior and attitudes.

9. Service Linkages

As noted earlier, the case management functions of the program are usually very important. Staff in these programs spend a considerable amount of time understanding the whole ecology of the client or family, and often must provide concrete services or solutions to daily living problems before they can gain the trust and ability to delve into other levels of functioning. Therefore, it is very important that the program establish and maintain linkages with other agencies that have major impact on children. These include schools, juvenile justice facilities, courts, and child welfare agencies.

Unlike the client population of many majority agencies, the client populations of ethnic-specific programs tend to be more heterogeneous. The program may have children referred from child welfare, mental health, juvenile justice, health clinics, the schools, or substance abuse agencies. Usually the agencies have multiple funding sources and categorical funding for certain types of youth. However, these programs tend to demonstrate that ethnic minority children and families have similar problems and concerns regardless of the door through which they enter services. Therefore, Ada S. McKinley Intervention Services can provide a similar program for ethnic minority children and families with mental retardation/developmental disabilities, mental health, or juvenile justice issues. Unlike majority programs that specialize in one component area, most of the selected programs tend to provide services over a broader spectrum of children and families.

The programs also tend to be responsive to the perceived needs of the community and often develop new services around these needs. For example, both Progressive Life Center and Roberto Clemente Center are experimenting in developing support groups for ethnic minority AIDS clients and their families. The Black Family Development Center has developed a special, culturally oriented support group for substance abusers. These programs, by necessity, often have multiple service linkages.

10. Use of Natural Helpers and Community Resources

In addition to linkages with other agencies, these programs often maintain and utilize linkages with informal community resources, networks, and natural helpers. The strength of many of these programs lies in their knowledge of and ability to mobilize these informal networks and natural support systems for their clients. These programs are adept at identifying community

leaders who are natural helpers and utilizing them as brokers between the formal and informal treatment systems. Given the strong spiritual orientation of these ethnic minority groups, churches and spiritual leaders often are key allies in the treatment process. Most programs acknowledge and understand that clients often use other levels and types of support that are available to them.

Further, community centers, churches, and other community social settings are often used to deliver services to families. In relying on these natural resources, the programs come to be seen as community resources and an important component of the services available in the community. These programs often participate in or sponsor cultural activities that reinforce perceptions that they are true community resources. The Soaring Eagles Program, the MICAS program within the South Cove Community Health Center, and Roberto Clemente were very effective in utilizing informal, natural networks and community resources to further therapeutic goals for their clients.

11. Treatment Goals and Evaluation

The focus and end goals of the treatment process are not simply individual improvement or well-being. There is a recognition in most of these programs that larger external issues play a key role in the disabilities presented by their clients. Racism, discrimination, poverty, and lack of opportunity structures are often the context in which ethnic minority clients struggle. To address only the individual and "fix" him/her to fit into this context is neither desirable nor appropriate. Thus, the treatment goals in many of these programs must also address the larger societal context in which they, and their clients, operate. Staff not only view themselves as treatment professionals but also as advocates and spokespersons for their clients.

These programs often rally against societal injustices or inequities that impact on the well-being of their clients and their communities. They cannot often separate themselves from political and social stances. Thus, the Soaring Eagles Program staff were among the chief advocates for the development of a Native American magnet school in the city of Minneapolis; Roberto Clemente staff address the housing issues among Puerto Ricans in the Lower East Side of New York City, Progressive Life Center staff become actively involved in curbing violence and promoting Afrocentric education curricula in Washington, D.C., and South Cove staff participate in activities related to protecting Boston's Chinatown against urban renewal projects that threaten the well-being and continuity of the Chinese community. In order to be effective and to gain the credibility of the target populations served, mental health programs and service organizations must also demonstrate support to their communities on a number of levels that are not usually associated with these programs in traditional and non-majority communities. Yet, it is these and other activities that gain them the level of credibility and trust so that their services are utilized and sought after by ethnic minority clients.

Although very few of the programs had formal evaluation components, and this may be considered another of the major weaknesses in the field, there were indicators that the services they offered were regarded as important. By the indicators of service utilization and length of treatment duration, almost all of these programs show great effectiveness. They are able to

engage and maintain large numbers of ethnic minority families in treatment over long periods of time, thereby reversing the low utilization and retention rates cited in many majority treatment programs.

Further, the effectiveness of the treatment program seems to be evident when one reviews and evaluates the referral sources for these programs. Ethnic minority groups often have negative perceptions of mental health services and experience stigma when they come in contact with them. This experience has frequently occurred when they have been referred by another agency, not through a self-recognition and self-referral process. Indeed, many of the programs included in this monograph have shown an increasing reliance on self-referrals rather than referrals from mainstream agencies. This means that family members and clients are referring other families and people to these programs reinforcing the acceptance and perception of the program as a valued community resource. Increases in self-referrals also indicate another effectiveness evaluation measure – client satisfaction with services. Many of these programs have attempted to measure client satisfaction and have found high levels of satisfaction. The levels of staff retention are also evaluated and reviewed by many of these programs.

However, none of the programs can answer the question about which factors make culturally based programs more responsive to client needs or whether, in the long-run, these services are more effective in treatment outcomes for clients. Are the benefits from these services reinforced over long periods of time? Do certain treatment modalities tend to produce better results than others for ethnic minority clients? These and other questions have not been researched and, due to the poor level of evaluation efforts in these and most mental health programs, there is little beyond anecdotal data to answer these important questions. As a result, many of the programs recognize the need for and would welcome more systematic evaluations of their programs and activities. Some are attempting to link up with university researchers but, for the most part, evaluation funding and activities remain limited.

CHAPTER III

SUMMARY AND PRIORITIES FOR THE FUTURE

Critical Aspects of Cultural Competence

In order to truly head programs and policies towards cultural competence, there are some critical factors that should always be kept in mind. These include:

- All of us, both Euro Americans and members of ethnic minority groups, are ethnocentric. That means that we usually value our own group above all others. The concept of cultural competence applies not just to Euro Americans but to all of us who have been born, educated, and live on American soil. Very few things in the American institutional structure have prepared us to live harmoniously in a pluralistic and multicultural society. Therefore, every one of us needs to learn and practice from a culturally competent perspective.

- It is not necessary or possible to learn all about the numerous cultural groups and customs in this country. To try to do so often leaves one overwhelmed. Rather, the important thing in bringing about a true shift in attitudes and behavior is to accept one's own ethnicity and another's without judgment. In other words, the key attribute to learn is nonjudgmental tolerance based on the recognition that we all operate from an ethnocentric perspective.

- It is imperative to recognize the importance and acceptability of culture as a viable concept for ethnic groups since, in our society, ethnic cultures are often confused with the culture of poverty or other socioeconomic conditions. We must rid ourselves of the common belief that many ethnic minority groups do not have cultures that are worth respecting or that the major culture of these groups is a "culture of poverty" (e.g., African Americans) or a "culture of alcoholism" (e.g., Native Americans). We must accept that there are viable cultures within ethnic groups that have allowed them to survive and grow in the midst of alien and often hostile environments. Cultures of "alcoholism or poverty" are not the African American or Native American culture, but rather adaptations, for better or worse, that have come about in interactions with the dominant society. It is important, therefore, to accept, seek, understand, and utilize those cultural values and factors that have provided strength and sustenance to ethnic minority groups over time and incorporate them into treatment interventions and program designs.

- There is no one model or approach to cultural competence and knowledge development. Therefore, in our zealous attempts to become more sensitive to other cultures, we must avoid substituting one set of stereotypes for another (for example, the shift from viewing Asian Americans as the "yellow peril" to viewing them as the "model minority"). Any stereotype or overgeneralization, whether positive or negative, reflects cultural insensitivity.

- Cultural competence is a dynamic, developmental process and a state towards which we should strive, but it takes a long-term and consistent commitment to achieve. It is not something that comes to the individual, the agency, or the system through a one-shot, quick-fix approach. The process is ongoing and continuous.

- Cultural competence tends to evoke strong feelings and reactions. Although some of these reactions stem from the generalized response to any change, many are related to the historical interactions, hostilities, and fears that have often marked relationships between ethnic minority groups and the dominant society. In order to move towards cultural competence, there must be a willingness and courage to confront all the feelings and attitudes that cultural competence and change connote for the individual, the agency, and society in general. As Pinderhughes (1989) states: ". . . multicultural staff must be able to engage in dialogue about their differences in perceptions and experiences. Failure to provide the opportunity to understand and process these differences within a multicultural staff will lead to one of two outcomes both of which constitute unhealthy contextual conditions for empowering people: (1) staff will cover over the conflict in perceptions and orientation and block off the confusion, frustration, and strong feelings, causing an undercurrent of stress, tension, distrust, and suspicion . . . or (2) conflict will erupt and staff will become burned out and fatigued if they try to hammer out program and policy before they have an opportunity to understand cultural dynamics and the significance of cultural identity and meaning in relation to themselves, their clients, and their work together" (pp. 205-206). In other words, ongoing sharing, communication, and dialogue are essential. Opportunities for such sharing and dialogue must be built into the structure of the agency or organization seeking to become more culturally competent.

- The development of cultural awareness and cultural competence must be a distinct and separate activity and, at the same time, woven into every aspect of an agency's or system's operation. It must meet the paradox of being separate but integrated in order to be effective. When cultural diversity is simply integrated, it is observed that, like many American attempts at integration, it soon loses its relevancy and uniqueness and is quickly forgotten. Like the task facing most people of color, agencies must learn to be "bicultural"; that is, they must learn how to offer services that are relevant to the ethnic population that they serve and at the same time assist them in becoming more skillful and adept at handling the larger Euro American mainstream that controls and has power over the critical resources that determine success. The agency must incorporate ethnicity while at the same time providing the bridge to the rewards and benefits of the dominant culture. This is certainly no easy task.

- It should be acknowledged and recognized that cultural diversity and cultural competence require an understanding of the sociopolitical environment in which an agency operates. The goals and activities must take into account regional differences – the size of the ethnic minority population, the diversity of the ethnic minority population, and other factors that impact on the success of social change and movement.

In conclusion, the degree of cultural competence that agencies achieve is not dependent on any one factor. Attitudes, structures, policies, and practices are the major arenas wherein development can and must occur. Attitudes change to become less ethnocentric, patronizing, or biased. Policies change to become more flexible and culturally impartial. Practices become more congruent with the culture of the client, from initial contact through termination. Organizational structures support and enhance the growth of cultural competence. Cultural competence is based on valuing "differences" and the belief that it is all right to be different. Neither systems, agencies, nor professionals start out being culturally competent. Like other types of competencies, cultural competence is developed over time through training, experience, guidance, and self-evaluation.

Important Program Characteristics

Since there are so many questions about cultural competence and how it can be actualized in mental health programs for ethnic minority children and their families, this monograph provides program examples of how various agencies have begun to incorporate the concepts and principles of cultural competence within their policies and services. It is hoped that these program descriptions will stimulate all of us to strive more consistently and wholeheartedly towards the multicultural society we must create.

As illustrated through the literature review and the common characteristics of the programs utilized in the development of this monograph, there are certain factors that must be available for establishing more culturally competent programs. First and foremost, there must be a real commitment to developing programs and services that are strongly based on the needs and strengths of the ethnic minority communities. This suggests that needs assessments and planning are vital activities in the development of culturally competent services. Also, as illustrated by the programs included in this monograph, ethnic minority communities are dynamic and ever-changing, which means that the assessment and planning process is an ongoing one and not just a one-time exercise. Another obvious corollary is that planning and needs assessment activities must take place in the context of the community and involve the leadership and organizations that are respected in that community.

Another core factor in the development of culturally competent programs, as evidenced from those included in this monograph, is that agencies must strive to hire ethnic minority professionals at all levels of the agency. At the same time, they must offer the necessary training and skills development to make them effective with clients. Thus, just hiring ethnic minority professionals, many of whom are trained in very traditional programs, is not enough. Ongoing cultural training for all staff must be viewed as a critical component of the service program as well.

It appears that the flexibility needed to establish and change program policies and practices towards greater cultural competence is enhanced when the agency is ethnic specific, operates under the auspices of non-profit status, and has some diversity in its funding streams. It appears to be more difficult to transform programs that operate under larger bureaucratic or governmental auspices. It is also more difficult to shift the mission and focus when an agency is over-dependent on a funding source that does not encourage cultural competence.

Finally, it is critical that the program be viewed as a community resource. Thus, location of the program, other non-mental health services provided, and community perceptions and images of the program are important considerations. For the most part, these programs have, in a number of ways, attempted to demystify and destigmatize mental health services for ethnic minority populations. They have done this in a variety of ways that are addressed in the individual program descriptions, but all of the adaptations have been premised on the cultural values and belief systems of the clients to be served. Therefore, the service adaptations appear to be quite natural within a cultural context and framework.

Priorities for Future Activities

Despite the positive advances towards culturally competent services illuminated through the included program models and others, there are weaknesses in the field of mental health and human services that should be more systematically addressed if significant strides are to be made. There appear to be four critical issues that should be placed on the agenda as priorities for furthering cultural competence in our society.

Development of adequate and reliable cultural assessment measures

As noted earlier, assessment instruments and approaches that adequately address levels of cultural awareness and assimilation are not readily available. Although a number of self-help tools are currently in the developmental stage, cultural assessments have not yet been incorporated in the body of psychological assessments that are routinely administered to children and their families. Given that the level of acculturation, the level of ethnic identification, and the response to Euro American stressors are viewed as critical components in the psychological well-being and functioning of ethnic minority group members, adequate and reliable assessment tools are crucial.

Incorporation of cultural competence knowledge and practices in the training of human service professionals

The importance of incorporating cultural competence knowledge into the curriculum of schools and universities that train human service professionals is an issue that deserves immediate attention. Too often, mental health and other human service professionals complete graduate studies that do little to prepare them to meet the challenges of operating and practicing in a pluralistic society. Given the decrease in enrollment of many ethnic minority students in American graduate schools, such changes in curricula are even more urgent. Recent shifts in the curriculum and requirements at the University of California at Berkeley, which require that all students take some courses addressing different cultures, are a start. Other universities are in the process of reviewing their curricula as well. However, ethnic minority content and cultural diversity issues need to be taught in a standardized, uniform manner that encourages both knowledge dissemination, increased communication, and cross-cultural experiences.

Further, innovative training techniques and plans need to address the following:

- Increased public/academic linkages – from programs to colleges/universities and vice-versa.

- Utilization of non-degreed staff in training capacities – often indigenous community leaders and resources have much to offer the field, but the field does not recognize them as experts and treat them accordingly.

- Greater emphasis on experiential learning – this would include more non-clinical contact with particular ethnic groups or communities as a part of clinical training programs.

- More use of ethnic minority on-site consultants when the necessary representation of ethnic minority professionals on staff is not present. These consultants could provide ongoing training to program and administrative staff, as well as specialized consultations around particular cases.

- Conceptualizing supervision in a more positive manner and recognizing the important role it can play as a way not only to improve service delivery but also to provide additional staff training.

More funding for research and evaluation

The reviews of the literature suggest that there is much empirical research that must be undertaken before we can fully explain the impact of culture and ethnicity on a range of dimensions of mental health treatment. However, research studies that focus on these types of concerns are small in number. More attention needs to be paid to evaluation and research studies focused on the outcomes and effectiveness of culturally based programs and service intervention strategies for improving the well-being and mental health of ethnic minority populations. Although the National Institute of Mental Health (NIMH) has given priority to research focused on and including ethnic minority populations, much of the proposed research still works out of the old "deficit model" paradigm which compares the ethnic minority group to the majority. In almost all cases, the researchers are from the majority group as well.

As culturally competent programs become more numerous, it is also important that culturally competent research and evaluation methodologies be available to measure their effectiveness and outcomes. At present, many of the methodologies and instruments used in research are incompatible and culturally insensitive to the nuances of interactions and processes that occur in most ethnic minority communities. This is because most research methodologies are premised on a cause-and-effect approach, rather than on interactive, non-linear measurements. It is also important that a cadre of ethnic minority researchers be developed.

Development of strategic plans for cultural competency

There is an increasing awareness that cultural competency is a developmental and incremental process. For those agencies interested in proceeding towards cultural competency in a rigorous and prescribed manner, the development of a strategic plan for cultural competence achievement is a first and very critical step. A good example of strategic planning for cultural competence is illustrated in the Santa Clara County Mental Health Bureau program description. Another example of solid strategic planning in this area is the Ventura County Mental Health *Cultural Competence Master Plan* (1991). Although these plans were developed in very different ways, a planning process focused on cultural competency issues was essential. Another essential step in the planning process is an assessment of the current level of cultural competence within a given agency or organization at the policy-setting, administrative, practitioner, and consumer levels. Recent efforts by James Mason (1989) and Terry Cross (in press) should provide materials that will assist agencies in determining their current level of cultural competency and developing plans to increase this over a period of years.

CHAPTER IV

PROGRAM DESCRIPTIONS

ASIAN/PACIFIC CENTER FOR HUMAN DEVELOPMENT CHILD AND ADOLESCENT PROGRAM

Denver, Colorado

At the Asian/Pacific Center for Human Development, services are provided in 19 Asian languages and dialects. This practice is seen as very important in overcoming cultural and linguistic barriers, thus making services more accessible to Asian families.

Brief History and Identification of Agency

The Asian/Pacific Center for Human Development (A/PCHD) is a non-profit state-certified community mental health specialty clinic serving refugee, immigrant, and the native-born Asian/Pacific population of Colorado. This multiservice center, which provides services in 19 Asian languages and dialects, was originally established as the Asian/Pacific Development Center (APDC) in 1980 and began contracting with the Colorado Division of Mental Health for services to the Asian/Pacific population residing in Colorado in 1982. Consistent with the four types of agencies serving minority populations described in Volume One of the *Towards A Culturally Competent System of Care* monograph, the A/PCHD is an example of the kind of agency which provides bilingual/bicultural services. Indeed, all of A/PCHD's program and policy implementation activities rest on the premise that cultural and linguistic barriers are best overcome through multicultural staff who have more than one language, and who are sensitive to cross-cultural issues.

The A/PCHD is one of two affiliate organizations which was established in 1987 by the Board of Directors of APDC. The other affiliate is the Asian American Foundation of Colorado (AAFC). The APDC provides the A/PCHD and the AAFC with management support, including administration, business, financial, and property management. Each has its own board of directors. The AAFC was established to raise funds for mental health and social service programs undertaken by A/PCHD as well as to provide public awareness and education on issues of Asian interest.

Community Description

Ninety percent of the Asian/Pacific Colorado residents reside within the five Colorado counties surrounding Denver. Most of the programs of the A/PCHD serving this population are located in an old mansion close to downtown Denver which is easily accessible by public

transportation. The facility was remodeled to include two well-equipped kitchens for clients and staff since cooking and eating together is an important tradition for Asian people. A greenhouse was added so that clients from rural Asia can experience horticultural therapy throughout the year. However, one of the A/PCHD programs, the Asian Youth At Risk Program (a United Way-funded collaborative program of the Boulder Mental Health Center and A/PCHD), is housed at the Mental Health Center in Boulder, Colorado. Boulder is a university town in the heart of the Rocky Mountains.

Target Population

The Asian/Pacific groups are the fastest growing minority population in the state. They have increased by more than 100 percent, from 29 thousand in 1980 to 60 thousand in 1990. The Outpatient Mental Health Services Program of the A/PCHD had a total enrollment of 390 clients in fiscal year 1989/90, consisting of the following ethnic groups: Japanese, Korean, Vietnamese, Cambodian, Chinese, Laotian, Laotian/Hmong, Filipino, Thai, Asian Indian, Samoan, and Indonesian. Approximately 10 percent of these clients were age 17 and under. At the time of the site visit, there were 60 children from 20 families, age zero to 21 years being served in the Asian Youth At Risk program. Forty-seven percent of the population is male and 53 percent is female. According to the State Refugee Coordinator, the refugee population estimates for 1990 were as follows:

Vietnamese (includes ethnic Chinese)	6,200
Lowland Lao	2,400
Cambodian	2,100
Hmong	1,900

The 1980 census figures for other Asian groups were as follows:

Japanese	10,000
Chinese	8,000
Korean	15,000
Filipino	3,500

Program Philosophy and Goals

The mission of the A/PCHD is to provide health, mental health, and social adjustment services to Asians and Pacific Islanders residing in Colorado, and to provide training and consultation to other agencies serving the Asian population. The specific goal of the Child and Adolescent Program is to develop and implement programs which promote an emotionally healthy environment for all Colorado Asian children and their families. The programs must be systemic in nature and involve the parents, peers, schools, and other child-serving agencies. Programs should be developed and implemented which place an emphasis on health and which help prevent problems from occurring in the first place. A/PCHD strongly believes that an emotionally healthy environment can only be accomplished if the strengths of each Asian culture are acknowledged, valued, and preserved. Maintaining a sense of being Asian is seen to be as important as

becoming "Americanized." The center respects each person's own history as well as the Asian client's own particular method of making him/herself better. There is also a recognition that everyone has a gift and that clients should be assisted in their efforts to give back to their communities. Furthermore, there is a shift away from verbal talking models to dance, formal arts, and recreational types of therapy.

SERVICES

The A/PCHD center is composed of three divisions; clinical, training, and vocational. The Division of Clinical Services provides outpatient mental health services, alcohol and substance abuse assistance and counseling, and domestic abuse services. Outpatient mental health services include 24-hour emergency care, psychological and psychiatric evaluations, evaluations for school children, and individual, family, and group therapy. Other outpatient services include partial day treatment, case management and outreach, medical screening, English as a second language, and marital counseling. In addition to regular outpatient services, current child- and adolescent-focused programs are provided through the Asian Youth At Risk Program and the Asian Youth Peer Counseling Program. There is also an Asian Youth Advisory Committee.

As stated previously, the Asian Youth At Risk Program is a United Way-funded joint project of the Mental Health Center of Boulder County, Inc., and the A/PCHD. Although the program is administered by the Mental Health Center, culturally relevant supervision is provided by the A/PCHD. The specific goals of the Asian Youth At Risk Program are: (1) to provide outreach, case management, mental health and family counseling, and access to other health and human service agencies for troubled Asian youths in Boulder County; (2) to prevent Asian youth from dropping out of school and to promote self-sufficiency; and (3) to develop a volunteer mentoring program in order to provide an ongoing support network for Asian youth.

The Asian Youth Advisory Committee is a multiagency, multidisciplinary, and multicultural committee which meets monthly at a local health clinic in Boulder, Colorado to provide support and guidance to the Asian Youth At Risk Program.

The goal of the Asian Youth Peer Counseling Program is to develop leadership among Asian youth so that they will become positive role models for their peers. The training for the program focuses on developing skills in career development, communication, active listening, assertiveness, self-awareness, problem solving, interracial relationships, alcohol and drug refusal skills, problems in dating, confidentiality, and leadership. The criteria for participation in this program includes high school students between 14 and 18 years of age who are of Asian descent and who have potential leadership qualities. In order to help the students develop a healthy, bicultural identity, particular emphasis is placed on Asian cultural identity and Asian values clarification. College age Asian students are recruited and assigned to a small group of trainees as discussion facilitators during the peer counseling training sessions. Peer counseling certificates are awarded upon completion of the training.

FUNDING

The total agency operating budget is $725 thousand. The percentage of funding from each funding source is as follows:

Medicaid	46.7%
Public Support (Foundation, Corporations, Individuals)	17.3%
City/Local Government Grants	14.4%
State of Colorado	7.9%
Client Fees	5.2%
Other	6.0%
Third Party Reimbursement	2.0%
Federal (Grants)	.5%

The AAFC is committed to raising funds through grants, private and public donations, and annual fund raising activities such as an Asian New Year Celebration, a Spring Fashion Show, a Festival of Asian Arts and Culture, a Pampered Peddler Bike Event, and a Casino Night/Membership Drive.

The Asian New Year celebration draws all Asian cultures together at a Denver area Asian restaurant. It is an evening of good food, celebration, and a fun and exciting silent auction.

The Spring Fashion Show presents fashions from the various Asian Colorado Communities with a different community highlighted each year. Fashions are available for sale and an Asian boutique is open to interested shoppers. A gourmet luncheon is included with the price of admission.

The annual Festival of Asian Arts and Culture is one of the most important fund raising activities undertaken each year. Each summer the AAFC Board of Trustees selects an Asian country to highlight during a two-day event. While the festival celebrates all Asian cultures, emphasis is placed on the "host country." For example, the 1990 Annual Festival of Asian Arts and Culture featured the Philippines. The Filipino communities of Colorado reconstructed a typical Filipino village, made sure that Filipino foods were available for tasting, and brought a variety of Filipino songs and dances to the performance stage. Among others, the Filipino Consulate General and Ambassador joined in the festivities and activities.

The Casino Night/Membership Drive is an opportunity for the AAFC to tap into new members and make sure current members renew their membership. In addition to traditional casino activities, there are raffle drawings, an Asian boutique, and a silent auction.

All of the above activities depend on major corporate underwriting, private and public donations, and the cooperation and participation of the Colorado community.

Program Efficacy

The Asian Youth At Risk Program has been so extremely effective that the Asian Youth Advisory Committee has recommended that this program serve as a demonstration project for United Way programs nationally. Not only is the target population being served, but the program has extended its consultation work to other segments of the community as well. The program is seen as visible and effective in educating the community and it is also seen as meeting the needs of Asian youth and their families. The effectiveness of the service is measured by an evaluation process involving a multiagency and multicultural advisory committee which meets on a regular basis. Another mechanism for determining the effectiveness of the program is through a record keeping and tracking process which provides information regarding the extent to which stated goals and objectives have been reached. Objectives include the number of clients served, the number of case-management contacts made, the percentage of high-risk youth remaining in school, and the number of volunteer mentors recruited and trained.

Cultural Competence Principles

Acknowledgement of unique issues of bicultural/bilingual status

In developing and implementing mental health and related services for the 60 thousand Asian/Pacific Colorado residents, the A/PCHD utilizes a number of culturally competent principles. For example, because of language barriers, one service adaptation that is seen as absolutely necessary is responding to access issues by providing bicultural/bilingual services. Based on a population study, the center recruits and hires bilingual/bicultural staff representing the client population. The major sources utilized for recruiting staff include community networking efforts, Asian-oriented newspapers, and staff who have connections in the Asian community. As stated previously, A/PCHD provides services in 19 Asian languages and dialects including Japanese, Chinese, Korean, Vietnamese, Cambodian, Laotian, Laotian/Hmong, Filipino, Thai, Asian Indian, Samoan, and Indonesian. Because of the variety of subgroups which comprise the Asian American populations, a variety of programs is necessary.

Because of the bilingual/bicultural skills of most of the A/PCHD staff, there tends to be over-utilization of services by the community, including after-hours work. Because many of the clinicians reside in the Asian community, there is the expectation by some community members that clinicians should be "all things to all people." The bilingual/bicultural clinicians help clients to cope with psychological and emotional problems, as well as to develop life skills which are necessary for adjustment to American society.

It is significant that the Asian community is experiencing an inevitable rise in the numbers of American-born and/or reared children of Asian immigrant families, aggravating cultural differences between child and parent. For example, the child-rearing practices in the Hmong families are vastly different from those in American families and even from those in other Southeast Asian families. Close communication between children and parents is not practiced in the Hmong culture and thus children have not learned how to communicate with their parents

when there are concerns or problems. However, in the school setting, children must learn to ask questions and speak up for themselves. At home, when they ask questions, this behavior is not accepted by their parents, and causes conflict. With less exposure to the Asian traditions of extended family and authority, the child becomes more likely to identify with more permissive American family and societal structures. The confusion that this engenders for the Asian parent alienates parent and child, and creates an intergenerational gap difficult to bridge. The Asian Youth At Risk Program, by providing case management services to Asian youth and their families, attempts to bridge this cultural gap. Since the case manager speaks the same language and is familiar with the culture, some of the barriers to utilizing mental health services are removed, making it easier for the children and their families to gain access to needed services. This program, therefore, provides opportunities for family involvement and empowerment in the treatment process.

Not only does the A/PCHD provide bilingual/bicultural services through the Asian Youth At Risk and other programs, but the center has also implemented an Interpreters Bank to ensure that refugees and recent immigrants lacking English proficiency receive quality care and equal treatment under the law. The bank can be used as a community resource by the medical, legal, and general business community in providing assistance to refugees and recent immigrants. The Interpreters Bank may be accessed on a 24-hour basis, seven days a week. It provides face-to-face interpretation and document translation services through 40 trained interpreters who speak any one of the languages available. This program assists service providers in effectively communicating with their clients.

Family as the primary system of support and intervention

The concept of family in the Asian community is usually interpreted broadly and includes uncles, aunts, other relatives, and members of the Asian community. At least 90 percent of the children seen at the A/PCHD are from intact supportive families. Treatment tends to be much more family and group focused than individually focused. Significantly, a theme during the 1989 Festival of Asian Arts and Culture was "We Are Family." This theme symbolizes the importance which the Asian cultures place on the family.

Importance of cultural assessments

The center is sensitive to the differential rate of acculturation among family members. If the parents are traditional, bilingual/bicultural clinicians are assigned. Since children tend to speak English and are more acculturated, American-born Asian professionals are then assigned to work with the family. For tradition-bound clients, male clinicians are usually assigned. Usually, ethnic clinicians act as the treatment coordinators to the family, even though each member may see different clinicians. Ethnic case management staff assist the family in obtaining additional services outside of the center. One of the major differences between Asian and Western cultures is the emphasis placed on the group versus the individual. Asian countries tend to be very homogeneous. There are certain rules and roles by which everyone is expected to abide, whereas, in American society, there is more of an individualistic perspective. Americans are seen by Asian parents as being too verbal and too open with their social lives. Unfortunately,

according to the Director of Child and Adolescent Services, there is only one direction in the acculturation process which is rewarded by society, and that is the direction of becoming more Americanized. If the child is to succeed in American society, it is obviously very important for him/her to become fluent in English and to understand the social values and practices of this society. Conflicts with parents are frequently symptomatic of the dilemma faced by the Asian family when two radically different world views come into contact with each other. One of the most frequently heard complaints among Asian American students is being accused by their parents of becoming "too Americanized." There is a great fear among Asian parents that their children will not maintain their Asian identity. By the time a child enters adolescence, the cross-cultural conflict has intensified to the point where the rift between parents and child has become very wide.

Asian girls are faced with a unique set of problems which place them under even greater stress than their male counterparts. Asian females are valued less than males in Asian cultures. The most valued positions in the family are that of the father and number one son. If an Asian female becomes assertive and verbal, it is viewed as a direct challenge to male authority. It therefore becomes difficult for an Asian American female to be successful in American society and maintain a sense of "Asianness" even if she wants to do so.

Hmong girls face a particularly difficult situation. Marriages are arranged in their early teens and they often drop out of school by the age of 14. Some return to school as married girls with two or three children. It is difficult for them to identify with their non-Asian peers who are just beginning to date. Dating itself presents a whole array of difficulties for Asian American students. For some very traditional Asian families it is not even considered proper to date. Many Asian adolescents long to have a boyfriend or girlfriend, but do not want to be labeled as a "bad" son or daughter. They see how non-Asian teenagers interact and they long to be able to have a friend of the opposite sex. The only time they can openly enjoy each other's company is when they are at family gatherings. Some find themselves sneaking out at night to be with their friends. Many others find themselves becoming more and more isolated, not able to turn to their parents and afraid of going out with their peers. They resent their parents for placing such restrictions on them and some find themselves openly rebelling.

Since most schools welcome the additional support of a mental health worker coming in to work with the students, both the Asian Youth At Risk Program and the Asian Youth Peer Counseling Program are seen as valuable resources by the schools and the A/PCHD is able to address the issue of the level of acculturation and assimilation through such programs. In both instances, there are close working relationships between the center, the school, and the home.

Concept of responsive services

The A/PCHD has demonstrated its commitment to providing culturally competent services by operationalizing the concept of responsive services matched to the client population. The board and staff of the APDC conducts periodic community needs assessments in order to identify priority Asian community needs which are not being met by the A/PCHD. For example, it was because of a key informant needs assessment survey that the center implemented programs such

as the Interpreters Bank and the Asian Youth At Risk Program. The center celebrated its tenth anniversary in October 1990, and the board and staff planned a special celebration to include an evaluation of the center's ten years of achievement and to identify the changing needs of the Asian and Pacific Rim Communities of Colorado.

Working with natural, informal support systems

The Asian Youth At Risk Program has as one of its major goals a volunteer mentoring program to provide ongoing support networks for Asian youth. These mentors are Asian students at the University of Colorado or other area colleges who are recruited and trained by the program. In this connection, the Hmong Women's Educational Association was established to provide mentors for younger women and to help young married women to be more independent. Workshops about cultural differences were planned and professional women were invited to speak to the group. However, the group ran into strong opposition from Hmong males, who traditionally hold a position of dominance within the Hmong society. Threatening notes and phone calls were received from males who feel that women should stay home and have children rather than be successful in the working world. The program nevertheless hopes that these natural helpers will help Hmong women feel more comfortable in American society and teach them that they can be successful in reaching their goals.

Significantly, an A/PCHD key informant survey meeting led to a recommendation to establish a mentorship program for Asian high school girls in order to meet the needs of Asian youth who are caught between American culture and that of their parents. Twenty girls from all over the Denver metropolitan area were selected and placed with Asian working women who served as mentors. These girls received a paycheck for their work, but, more importantly, they developed a close teaching/learning relationship with Asian working women.

The Peer Counseling Program is still another example of the use of natural helpers in providing services to Asian youth. According to the executive director of the A/PCHD, this program has demonstrated effectiveness in assisting youth suffering from a variety of problems since many of them are unable to discuss such problems with adults. As stated earlier, peer counselors are expected to become positive role models for their peers who are middle and high school students and who are experiencing difficulties.

Provision of an integrated network of services

The Asian Youth At Risk Program is an excellent example of a program that was planned, designed, developed, and is being implemented through interagency coordination of activities. The joint implementation of this project by the Mental Health Center of Boulder County and the A/PCHD brings the back-up resources of a full comprehensive Mental Health Center and the cultural expertise and resources of the A/PCHD together to provide integrated services to troubled youth. An advisory committee, with representatives from social services, the People's Clinic, the schools, law enforcement, and private practitioners, provides additional support, monitoring, and back-up resources to the project. The Interagency Advisory Committee evaluates the program and makes recommendations for improvement.

During the time of the site visit to the Asian Youth At Risk Program, a multicultural interagency task force was meeting at the People's Clinic in Boulder to plan a "Festival for Unity." Two of the objectives of the Festival for Unity as articulated by the Interagency Task Force were: (1) to honor the diverse cultures represented in the area as well as to provide an environment for community members to share their own traditions and differences with others, as well as with the community at large; and (2) to strengthen the bonds of all people while acknowledging and celebrating strengths and differences through a multi-ethnic and multicultural approach.

Public agencies committed to this effort included the Department of Social Services, the Department of Health, the People's Clinic, a crime prevention program, the AIDS Prevention Project, the Community Parenting Center, and a Family Housing program. Through activities such as these, it appears that the People's Clinic assumes a leadership role in organizing the community around issues of identifying and meeting community needs at the grass roots level. The clinic, through such activities, identifies itself as a focal point for interagency coordination. Some of the key informant surveys of the A/PCHD were held at the clinic and the Asian Youth At Risk Program uses the facilities at the clinic to provide services to its clients.

Because the Asian Youth At Risk Program utilizes the case management approach, interagency coordination is central to the successful implementation of the program. There are strong linkages to the Boulder public schools as well as with such community programs as Community Parenting Centers to provide activity groups for children.

Since one of the major goals of the A/PCHD is to provide training and consultation to other agencies serving the Asian population, interagency coordination is a major activity of the center. Center services are provided on site at community agencies, schools, hospitals, health clinics, and social agencies. There are also strong linkages with professional schools and universities in the area since A/PCHD serves as a professional training site for students.

Staffing patterns and ethnic composition

Still another cultural competence principle that the A/PCHD utilizes to an outstandingly effective degree is that of having an agency staffing pattern that reflects the makeup of the client population, adjusted for the degree of community need. As stated earlier, services are provided in 19 Asian languages and dialects. The staff of the A/PCHD consists of 29 members, including 23 treatment staff, and 6 support staff. There are 8 males and 21 females with an average age of 38 years. There are 16 professionals and 7 paraprofessionals on the staff. The center also contracts with a psychiatrist and a social worker who are Asian Indian. Additionally, the Asian Youth At Risk Program is staffed by one full-time Hmong-speaking case manager who is supervised administratively by a senior staff member of the Mental Health Center of Boulder County, Inc. In selecting staff, the A/PCHD looks for Asian-born staff who speak fluent English and one or more Asian languages. The staff member must be committed to serving his/her community. If identified with a particular ethnic or community association, he/she must be able to work effectively and be viewed with respect by the other communities. The Asian American and non-Asian staff must be respected professionals and be interested in working with Asians.

Staff are required to get as much education as possible, since education is highly valued in the Asian culture.

Because of the heavy demands for services, staff burn-out is sometimes an issue. Sixteen percent of the staff left the program during the last year. Exit interviews are held which provide valuable information used to improve services and working conditions. Some of the mechanisms utilized as staff retention tools are: devoting time to training staff in "English as a second language"; training in abnormal psychology and other ongoing inservices as indicated; a philosophy of educating a second generation of clinicians which encompasses the notion that "it is not my life that is important, but the group life"; looking at succession possibilities (this is in contrast to certain American values that stress "career and retirement"); selecting staff members because of their level of competence; and providing flex-time for staff to study towards a higher degree at local universities and graduate schools.

Cultural competence training

All staff members are involved in weekly supervision, as well as bimonthly staff meetings and training. Two opportunities are provided annually for staff to attend workshops and conferences. Additionally, all clinical staff receive weekly clinical inservice training on client cases. Cultural issues are almost always the center of the discussion and learning. At the time of hiring, all candidates (including support staff) are presented with specific situations involving Asian clients. Answers are analyzed closely and the level of knowledge, cross-cultural sensitivity, and compassion is evaluated. The Director of Child and Adolescent Services is responsible for designing culturally competent programs and for establishing a comprehensive array of services, including the provision of culturally competent training to staff, interns, school and other agency personnel who work with Asian children and adolescents. As such, training for mental health professionals in the delivery of culturally sensitive services is provided. Student interns from the University of Colorado, University of Denver School of Professional Psychology, Colorado State University, Denver University School of Social Work, and the Iliff School of Social Work receive training at the center.

The Division of Training provides various educational and training workshops to both the general public and the Asian population, aimed at those working for and with Asians, leading to increased awareness, cultural sensitivity, and understanding.

Minority participation at all organizational levels

One area in which the A/PCHD has exhibited strength is that of minority participation in planning, governing, administering, and evaluating the development and implementation of services. From the needs assessment survey meetings, to minority participation on the center's three policy making boards, to the center's recruitment and hiring practices, to the strong advocacy role of the Asian executive director, and the center's Tenth Anniversary year which involved clients, staff, board, service providers, and the community at large in evaluating programs and planning future direction, the A/PCHD utilizes the cultural competence principle of minority participation in an exemplary manner.

Support of self-determination for the broader minority community

Because board members represent the community and are from diverse backgrounds, they have been effective in governing the center in such a way that community needs are being identified and met. As a policymaking body, the board believes that one of its major responsibilities is to become thoroughly familiar with the Asian community and to utilize its members' expertise and background to effect positive changes in center services so as to meet the needs of the Asian community. The 1990 Board of Directors included members from the University of Colorado faculty, a representative of the Denver Mental Health Corporation, a director of a communications/public relations firm, a psychologist in private practice, a social worker who is director and therapist at a day treatment center, two attorneys-at-law, a lecturer at the University of Denver, an assistant professor at a graduate school of social work, a census community awareness specialist, and a teacher/mediator/trainer in private practice. In establishing policies, the board takes into consideration cultural issues through such activities as assuring that key informants from the Asian community are involved in the agency's needs assessment and that agency and program goals are consistent with culturally competent policies and practices.

Significantly, the A/PCHD has a very high degree of political support in the state of Colorado. One indication of that support is the fact that during the 1989 center-sponsored Annual Gala Dinner to honor visiting dignitaries and to raise funds for the center, the governor, congresswoman, and mayor were in attendance. This dinner was one of the activities connected with the Festival of Asian Arts and Culture. High-level local, state, and national political leaders are listed as friends of AAFC. Moreover, the executive director of the A/PCHD has an extraordinarily high level of understanding of the legislative and executive processes in the state of Colorado. This means that the center has access to information and the decision making processes in Colorado.

Due to strong advocacy at the executive level, the dedication and commitment of three separate boards of directors, the liaison with state government, the nature of interagency coordination mechanisms, the high level of support from the Asian community, and the number of center-sponsored educational and cultural enrichment programs open to the public, there is considerable political support and a positive climate for promoting center services. A quarterly newsletter published by the center, entitled "Bridging Diverse Cultures," keeps the community informed about center programs, needs, and activities. All of these activities are in support of self-determination for the 60 thousand Asian/Pacific residents of Colorado.

BLACK FAMILY DEVELOPMENT, INC.
Detroit, Michigan

It is significant that the programs of Black Family Development, Inc. are designed to implement three basic concepts: empowerment, intactness, and parents-remaining-in-charge with a goal of preventing separation of children from their families while strengthening and enabling families to become self-determining.

Brief History and Identification of Agency

Black Family Development, Inc. (BFDI) is a private, non-profit, comprehensive family counseling agency which was established by the Detroit Association of Black Social Workers (DABSW) in 1978. From the onset, the DABSW sought to promote and provide quality social work services to Detroit's African American community. Based on agreed upon needs, BFDI's initial focus was on child abuse and neglect. The agency's focus has since expanded to accommodate increasing demands for a variety of specialized counseling services in the African American community. Consistent with one of the four service delivery models described in Volume One of the Culturally Competent System of Care monograph, BFDI is seen as a minority agency, providing services to members of a minority community. According to BFDI, Detroit's African American community knows what services are needed, and is able to design and implement programs that meet these needs appropriately.

Community Description

BFDI is located in Detroit, Michigan, an urban area whose population is approximately 65 percent African American. Detroit has numerous strong, active churches. The mayor of the city is African American, and some of the neighborhoods are solidly middle class. Prior to the decline of the automobile industry, people from the south and other parts of the country migrated to Detroit in record numbers to seek employment in this once-thriving metropolitan city. Today, numerous social problems associated with poverty, unemployment, and a depressed economy plague Detroit. Much of this is due to the decline of the automobile and related industries which threw many people out of work, thus impacting on the ability of Detroit's African American families to provide for their members. Violence among young people, high murder rates, homelessness, a 46 percent school drop-out rate, teen pregnancy, limited supply of low income housing, and drug use including crack cocaine and alcohol abuse are serious problems in Detroit. There are approximately 600 thousand children under 18 years of age in Detroit and Wayne County. Of these, more than 120 thousand are considered to be significantly at risk of failure in one or more areas of social, emotional, or physical functioning (Juvenile Justice Briefing Session 1990).

Target Population

BFDI's client population is Detroit and Wayne County African American families from all socioeconomic levels. BFDI provides direct and referral services, as well as consultative services

to groups and agencies advocating for the development of African American families. Thus, any African American family requesting services may be served by BFDI through any one or a combination of their 14 programs. Approximately 593 children are served annually. Thirty percent of the clients served are male and 70 percent are female. The age range of children and adolescents served is from zero to 18 years of age.

Program Philosophy and Goals

BFDI has a caring attitude in serving African American families, and has developed a code of ethics which guides service delivery to these families. This code recognizes that there are diverse structures based on kinship and other nurturing relationships within African American families which enable these families to maintain and develop the positive functioning of each member. It acknowledges that adult members have the greater responsibility to sustain family relationships, and that BFDI must reach out to provide services to Detroit's African American families no matter where they are geographically and experientially. These services are designed and implemented around a Home-Based Services (HBS) model which is seen as an effective, efficient tool in preserving families.

Programs are designed to implement three basic concepts: empowerment, intactness, and parents-remaining-in-charge with a goal of preventing separation of children from their families while strengthening and enabling families to become self-determining.

Services

HBS are offered through 14 programs, including counseling to prevent out-of-home placement, in-home care, an out-patient drug abuse program, substance abuse prevention services to African American youth, a black AIDS Awareness Research Initiative, and an AIDS Program. Other services provided include a Teen Pregnancy Prevention Program, services to "at risk" pre-schoolers and their families, a tutoring program designed to enhance the reading ability of children and adults, a substance abuse training program, a consultation and training program which enhances other organizations' abilities to serve African American families, and general family counseling. These programs are supported by a number of ancillary services such as parenting education, child play therapy, women support groups, and teen rap groups.

Funding

BFDI has a budget of approximately $1 million and a diversified funding base. Funding sources, and the approximate percentage of the budget from each funding source, follow:

Michigan Department of Social Services	40%
Southeast Michigan Substance Abuse Services	16%
Skillman Foundation	12%
Michigan Department of Public Health	10%
Detroit Public Schools	10%
United Way	9%
Fund raising	2%
Bureau of Substance Abuse - City of Detroit	1%

Program Efficacy

BFDI places considerable emphasis on program evaluation. For example, it has a quality assurance (QA) program which includes a peer review process, program review by a standing committee of the board, client satisfaction surveys, case record reviews, and program evaluations by independent consultants. The major findings of a program outcome evaluation by an independent evaluator for the period April 1988 to April 1990 revealed that the program demonstrated compelling effectiveness. Not only were high-risk African American families identified, but the program was successfully recruiting and retaining extremely high-risk African American families. The visibility of a van in high-risk neighborhoods and at sites which attract the attention of high-risk family members (e.g., Department of Social Services parking lots, public housing authorities, food banks, and pantries) increased awareness of, and referrals to, the program. Additionally, the program completed all process goals for the first year and the program goals, objectives, and procedures were refined. Moreover, the program staff and agency administrators made adaptations relative to the needs of the intended populations.

An independent evaluation of the HBS program in October 1989 concluded that the program provided services consistent with contractual mandates and guidelines set forth by the Department of Social Services. In response to needs identified in the client population, the program expanded its services beyond the initial service mission. For example, BFDI developed a substance abuse treatment program, partly in response to the high incidence of drug use in the HBS client population. In addition to the QA process and the independent evaluations described above, BFDI conducts a number of other surveys and evaluations, including the Black Family Needs Survey, a Parent Service Evaluation Questionnaire, a Black Family Development, Inc. Board Retreat Evaluation, and workshop/presentation evaluations. All of these activities are designed to provide information which is used to improve or adapt services to meet the needs of the family. The answers to the following questions from the Black Family Needs Survey points the direction for program development and implementation:

- What do you see as the most serious problems within black families?
- What do you believe are the solutions to the problems?
- Do you think black families need specialized counseling based upon black culture?

Cultural Competence Principles

Acknowledgement of unique issues of bicultural/bilingual status

BFDI designs its programs to increase access and acceptability of agency services, thus removing barriers to service utilization that might otherwise be created as a result of the bicultural status of African American families. For example, the philosophy of one of BFDI programs evolved from the fact that in far too many instances the African American family operates in a vacuum. Culturally, African American people are reluctant to ask for help and thus

their problems intensify. By utilizing a strategic mobile outreach approach involving a bright colored van, this outreach service is both visible and accessible to the African American community. Information and referral, as well as crisis intervention on a one-time basis, is provided as staff "move" through various neighborhoods. This "eye catching vehicle" can also accommodate one or two individuals aboard the unit. The van is designed to include rear seats and a table top as well as storage space for information and referral material and resource items such as canned goods and other emergency supplies which families may need. The mobile van is staffed by a team of at least two counselors who are sensitive and receptive to both the needs and the struggles of the African American family. They are prepared to stop the van at any time and provide services on site. Furthermore, in order to make the service more accessible to potential clients, culturally appropriate music is played from the van. This attracts attention, which leads to curiosity, information sharing, and requests for services. Such an approach goes a long way in addressing such issues as geographical isolation, early identification of mental health problems (which could prevent more restrictive interventions), help with concrete or tangible services which could keep the family together, and assistance in creating a comfortable atmosphere in which even the choice of music strikes a chord in the African American individual/family. These service adaptations communicate to the African American individual and family that BFDI is taking the time to understand and appreciate their culture.

Although the initial contact with BFDI may be through this mobile outreach program, families are then offered any number of other agency services, as appropriate, including: family counseling, crises intervention, emergency transportation, parent skills training, emergency food and clothing, teen pregnancy prevention, and substance abuse prevention. It is felt that this modified approach to case finding (use of the van) can prevent families from entering the child welfare and other systems. It is also a flexible and creative way of meeting the service delivery needs of African American families in a culturally competent manner.

Another BFDI program takes drug treatment services to the client adding a personal dimension that becomes vital when seeking to impact the cultural skepticism African American families have for the system. These services concentrate on family strengths and are available 24 hours a day, seven days a week. The purpose of this program is to provide outpatient drug abuse services to persons who either reside or work in areas with a high rate of drug abuse. Individual and family substance abuse counseling and treatment counseling for adolescents is provided. It is felt that families involved with chemical dependency must "face" the reality that the entire family has many problems. BFDI believes that the identification of problems and solutions should be from the perspective of the African American family and that all services should be culturally competent as related to the African American experience. This can be done through the use of a HBS approach in which a more realistic and constructive helping atmosphere is created, thereby enhancing the recovery process. Moreover, when families do come into the office (usually for group work services), BFDI is accessible as it is located either in the basement of the church in the client's neighborhood or on the main street of a Detroit residential area. The main BFDI facility is a one story brick building with 5,100 square feet of space, including offices, group and conference rooms, and a small play area outside for children. The name "Black Family Development, Inc." identifies the building and, once inside, there is a colorful map in the shape of Africa which depicts African American images. There is a child play therapy room with

ceiling-to-floor art work depicting African American families and created by an African American artist. Clients are treated warmly and are not left to wait in a waiting room.

Incorporation of cultural knowledge/preferred choices in practice and policymaking

BFDI works to assure equal access to competent services for African American families based on the knowledge of the unique circumstances of African American families wrought by the history of racism in this country. There is an awareness that economic, social, and political systems place stress on the family unit which, in turn, has a detrimental impact on family life. Moreover, BFDI endorses the concept of assisting alienated people in formulating their needs and obtaining assistance in addressing them. BFDI seeks to address the needs, values, and wants existing within the African American community such as the need for sustained economic stability of the family, need for humanized services, recognition of cultural values, accessibility of services, need for strong professional outreach services, development of African American youth, re-establishment of a neighborhood concept (community development), and recognition of the dignity of African American people. Current services which focus on the realities and strengths of the African American family unit are planned for and provided by professionals and paraprofessionals whose combined skills, cultural perspectives, clinical backgrounds, and commitment give confirmation to the validity of the African American experience. These experiences which impact on behavior and practices include: involuntary entry and settlement/location in the U.S., a long history of violent interaction with white society, a significantly different ability than other ethnic groups to assimilate due to skin color, denial of the right to continue speaking their native language and to continue other traditional practices during slavery, the use of strong survival techniques, not being perceived by society as having a unique culture, being intentionally separated from their families causing the extended family to take on a different meaning for African Americans, systemic racism, and the profound impact of church/religion on their lives. With an understanding of the impact of experiences such as those listed above, the BFDI is dedicated to caring, sharing, and serving African American families.

Some of the ways that cultural knowledge is included in practice and policymaking is through such BFDI programs as the AIDS program described earlier and through the READ program (Reading Enhances Awareness and Development). Although the READ program is designed to enhance the reading ability of African American children and adults, the reading material utilized relates to the clients' lives and experience. For example, African American history is often the content utilized as teaching material. Additionally, programs such as "Loving Our Own Kids" (LOOK) help parents to modify cultural practices so that these practices are appropriate in meeting community expectations. This help is offered through parent educational counseling in which training is provided on specific topics such as discipline, growth, and development. In play therapy with children, toys and games are reflective of the child's culture and world. Supportive services offered include: cultural and recreational experiences such as trips to museums in which African cultural events and arts are featured; transportation to parenting classes, to group sessions, and to other agencies and facilities as needed; providing food, clothing, and assistance with meeting other basic needs; offering academic tutorial assistance to clients on an as-needed basis; and providing quality child care to allow parents time to obtain resources to enhance their long-term independence.

Family as the primary system of support and intervention

BFDI sees the family as the primary system of support and preferred point of intervention for BFDI service delivery. Significantly enough, careful attention is given to understanding the unique family structures in the African American community as defined by the culture of these families. For example, the initial assessment is very extensive and includes obtaining identifying information, as well as a description of the presenting problems, from the perspective not only of the referral source and BFDI counselors, but also from the perspective of the nuclear family, caretaker, extended family, friends, and significant others as well. Comprehensive information about family members including an examination of the family support system, a review of use of leisure time of each family member, problem solving approaches, and parent-child relationships is assessed from both the adult and the child perspectives. Family members are seen conjointly and/or individually as needed, assuring a family focus and cultural sensitivity.

Importantly, families served by BFDI are often "non-traditional" in that they may include the extended family or anyone with whom the child or adult has a significant relationship. During a site visit to the program it was difficult to determine who were the identified clients. In fact, during a group interview, clients of all ages, both sexes, and those participating in one or more of the various programs were eager to share their perspectives, needs, and experiences as African American people with the site visitor. Present were adolescents, a pregnant woman, a father who was a psychiatric outpatient, a foster mother, and her son who was seriously emotionally disturbed. Regardless of the nature of the problem, or the specific program to which an individual or family was assigned, the common bond seemed to be one of identification with BFDI and its staff. In the words of one client (an aunt of a 13-year-old adolescent), "BFDI not only worked with my nephew who was an 'acting out' adolescent, but worked with my entire family. They gave me the confidence and self-esteem I needed to feel in control as a 'parent'." Indeed, one is left with the impression that the staff of BFDI serves as extended family members of their clients.

BFDI believes that it is critical when providing HBS to have a positive attitude and to do whatever is necessary to help families. The counselors who serve as motivators, teachers, supporters, advocates, option-builders, and information specialists attempt to convey a feeling of hope to the family. They seek answers to questions such as – What do families need? and How can BFDI best meet the needs of families?

By working with families in their own homes, BFDI is able to operationalize a family-centered, culturally competent approach to service delivery. Such an approach provides an opportunity for staff to develop close working relationships with families, thus facilitating the development of trust and respect. This approach also empowers the African American family to seek solutions to family problems which fit within the context of their culture. In fact, the names of some of the programs of BFDI are indicative of the importance which BFDI places on empowering families. For example, Save A Family Through Empowerment (SAFE) and Families Abstaining with Commitment to Empowerment (FACE) are the names of two of the programs at BFDI. BFDI utilizes the HBS model, which stresses family preservation, because of the belief

that children are best able to develop into healthy, productive adults when reared by their own families. Additionally, individual members benefit when the family is helped.

BFDI advocacy efforts are designed to support and defend the right of African American families to receive and have equal access to quality services that sustain and enhance the family through effective support systems, e.g., social, economic, educational, political, and health. At the policymaking level, whether with governmental or private sector organizations, BFDI takes the position that policymakers must accept responsibility for problem analysis, policy development, and provision of resources to implement programs and services that are in the best interest of African American families and community as defined by African American people. BFDI encourages individual service providers to make an individual commitment and accept full responsibility for sensitizing themselves and colleagues to the needs and concerns relevant to African American families. BFDI believes that families can and must be empowered, and it is through such empowerment, enhancement, and preservation of the family that problems such as drug abuse, AIDS, child abuse, and teen pregnancy, can be treated and/or prevented. Furthermore, BFDI believes that cultural sensitivity is vital in understanding family dynamics and in providing culturally competent services to the minority family and community.

Importance of cultural assessments

BFDI utilizes its understanding of acculturation issues and the history of African Americans in this country to give confirmation to the validity of the African American family's experiences in the United States. As part of the initial assessment process, cultural factors are evaluated; thus, such attitudes, behaviors, and beliefs as the mode of dress, religious beliefs, and family relationships/structures are considered in the design and implementation of case plans. Is the client wearing African attire, a head piece, or does he/she have an African name? Does the family belong to the Black Muslim faith? One needs to understand what these issues (identification with Africa and the Muslim religion) mean to African American families if one is to successfully modify services to fit client needs.

Facing Tomorrow is a support group that is seen as being culturally sensitive to the needs of African American addicts. This adaptation (a specialized culturally oriented support group) to service delivery involves instilling in recovering addicts a renewed sense of cultural awareness, family preservation, child development, and commitment to neighborhood integrity.

The Facing Tomorrow group is an alternative and/or adjunct to Alcoholics Anonymous and Narcotics Anonymous. It provides strong didactics and very intense group interaction. These are geared to focusing the addicts' attention on the past, present, and future ramifications of their addiction with other emphasis on becoming a viable person. Didactics are used to inform the addict of the African American experience, cultural relatively, sensitivity, family dynamics, and understanding the system, as well as how to work successfully within it. Very strong emphasis is placed on manhood, womanhood, and mother/father relationships as they impact on child development. The goals of Facing Tomorrow are to assist recovering addicts in their transition from drug-using life styles to productive, rewarding lives of abstinence; to instill in recovering addicts a renewed sense of cultural awareness, family preservation, child development, and

commitment to neighborhood integrity; and to instill within the black male addict a sense of urgency/responsibility as it relates to mainstreaming. This approach, according to BFDI, is effective with this traditionally difficult-to-serve population.

Concept of responsive services

In addressing the principle of providing responsive services matched to the client population, BFDI has chosen to implement all of its programs by utilizing a HBS model. BFDI believes that minority group members benefit greatly from this model. It is composed of nine major strategies that operationalize BFDI's empowerment philosophy: (1) in-home directed resources; (2) family-focused services; (3) crises-oriented services; (4) swift, careful intake assessments; (5) frequent in-home visits involving a team approach to service delivery; (6) skills teaching (e.g., parenting training); (7) small case loads; (8) parents remaining in charge; and (9) identifying and building on strengths. Additionally, the HBS model encompasses such key elements as: a philosophy of services which includes one's attitudes, purposes, and thoughts about being served. This philosophy is one that focuses on strengths and is imbedded in the counselor's attitudes and encourages him/her to approach the family initially from a positive perspective. Outreach extends beyond the family unit itself and includes the extended family and surrounding neighborhood. Supportive services combine culturally sensitive counseling and the provision of material items and support provided through a staff team approach with service accessibility 24 hours per day, seven days per week.

As a comprehensive and responsive African American family counseling agency, BFDI's mission requires addressing all types of needs, including the needs of persons either with AIDS or those at risk of becoming infected with the AIDS virus. Since AIDS is a very serious and often sensitive problem for African American families, BFDI's AIDS prevention program in the African American community includes assessing attitudes, beliefs, and behaviors as African Americans with regard to AIDS. The problem of AIDS among African Americans is exacerbated for several reasons. First, there are waiting lists for drug users needing residential treatment and few programs are available for HIV-infected people. Second, there are many myths in Detroit's African American community about the AIDS disease. Education surrounding these myths has primarily come from groups external to the community with little mobilization for education within the general African American community and high-risk populations. BFDI has uncovered several findings through its AIDS program, including the following: (1) the majority of African American youth are aware of AIDS, but this awareness has not translated into a reduction of "at risk" behavior; (2) many older African Americans feel that the AIDS problem is not their problem; and (3) many religious groups view AIDS as a direct consequence of God's wrath on sinners.

BFDI believes that the approach to AIDS education must include a growing progressive trend that places emphasis on instilling strong moral values and spirituality and promotes sexual abstinence among teenagers.

The BFDI AIDS program provides primary prevention services through information and education. These services are enhanced through counseling and support services in the African

American community but are especially directed toward youth, HIV-infected persons and their families, and families of AIDS victims. Case management services are provided to assure that HIV-infected individuals receive appropriate assessment, referral, and service.

BFDI offers AIDS awareness presentations to schools, churches, and community organizations as well as referrals for testing, counseling, and support groups.

Provision of an integrated network of services

BFDI has many linkages with other service providers in the community. For example, a number of interagency agreements exist such as a residential agreement for placement services. BFDI also participates in joint staff development activities with other service providers. For the HBS program, interagency coordination is a major element in the program design, implementation, and evaluation. Joint initial and ongoing assessments are done on each family by the referring agency and BFDI. Joint case review conferences and joint service plans are also completed on each family.

In working with the Detroit public schools, interagency coordination takes the form of staff/client/school and counselor interventions on behalf of students who are clients of BFDI.

Also, there is a substance abuse training program which trains lay people in church congregations to form support groups for drug abusers and their families. This program also identifies potential drug abusers and makes appropriate referrals.

Additionally, community-based network activities include working with other agencies and organizations around common community problems such as AIDS in the African American community. BFDI staff are also involved as committee members in dealing with such community issues as recreation, health care, family preservation, and homelessness in the African American community.

Staffing patterns and ethnic composition

BFDI staff consists of 32 African American members. The average age is 38 years and there are 12 male and 20 female staff members. Twenty staff members are professional and 12 are paraprofessional.

BFDI adheres strictly to the principle that staffing patterns and composition must reflect the makeup of the client population. In carrying out its mission, BFDI has elected to utilize a 100 hundred percent African American staff to serve a 100 percent African American population. BFDI believes that a 100 percent African American staff will help ensure that African American values are infused throughout BFDI programs.

The interviewing process for selecting staff involves a staff team consisting of colleagues, the clinical or program director, and the deputy director or executive director. This process is used because it is seen as one way of determining if a potential staff member has the ability to carry

out the agency's philosophy. Staff must have a caring, concerned attitude for African American families as well as life experiences which help them to understand and appreciate clients and families with special needs.

The executive director indicated that she tries to recruit the "best and the brightest" staff members, even though staff salaries are not competitive in the job market. It did appear that the staff was highly committed to meeting the needs of African American families and that there was a sense of esprit-de-corps at BFDI. One gets the impression that staff has "bought into" the philosophy of the agency and that everyone operates from the same set of underlying principles which focus on strengthening and preserving African American families. Moreover, staff seem to relate to each other in a warm, family manner.

BFDI uses various methods to recruit staff, including utilizing the professional networks. For example, the Association of Black Social Workers has an office at BFDI. Moreover, students receive training at BFDI and these students are also an excellent manpower source. Advertising to fill staff vacancies is done through the African American media in Detroit. There seems to be low staff turnover, at least during the past year in which the turnover rate was 6 percent. It is probable that the esprit-de-corps which exists at BFDI and the care with which staff is selected contributes to the high staff retention rates. Furthermore, BFDI submits its programs to independent evaluations and the administration does respond to recommendations of the evaluators regarding staff issues. For example, when "staff stress and frustration" was identified as an issue by an evaluation consultant, an immediate series of planning sessions was implemented. This resulted in improved staff morale, enhancement of the original goals of the program, and a shared administrative and staff consensus on program goals and directions.

Cultural competence training

BFDI provides culturally focused training for all staff, including administrative staff. This training involves reviewing philosophical constructs as they are the basis for methods of continued identification of cultural strengths within the clients. There is a one-day orientation for all new staff which includes cultural sensitivity training and a self-inventory (videotaped) which forces staff to examine their own values. "Think Tank" sessions are held and monthly staff meetings address skill development and cultural competence. Peer review is a part of supervisory sessions and regular staff meetings.

Staff are trained not only to utilize traditional methods (e.g., case management) of intervention in providing services, but also to consider ways to modify services (e.g., use of the mobile van and developing the capacity for providing services anywhere in the neighborhood) in order to fit client needs (accessibility). Cultural sensitivity training is done on a continuous basis and a staff retreat was held recently in which cultural issues were discussed. Moreover, as previously indicated, BFDI has a consultation and training services program in which training is provided to other organizations. BFDI staff consider themselves to be highly skilled in the area of cultural issues and have designed a workshop on the "Relevance of Cultural Sensitivity and Competency." The training and consultation program, which enhances the ability of other organizations to serve African American families, is provided by a team of highly skilled,

experienced African American professionals on site or at the BFDI facilities. The format includes lectures, discussion, role playing exercises, video presentations, and practical exercises. Counseling is also provided, utilizing an individual and group counseling format. Some of the training and consultation packages offered which focus on basic fundamentals in serving African American families include:

- A one-day workshop geared to helping human service professionals develop a clear understanding of how the African American experience is just as "unique" as the experiences of other American ethnic groups. Concepts such as cultural preservation, acculturation, personal attitudes, beliefs, and behaviors are explored.

- A one-day seminar involving in-depth discussions on culture designed to heighten awareness of culture and the importance of its being integrated into services.

- A one-day workshop in which strong emphasis is placed on understanding the African American family relative to the African American experience. This workshop also focuses on how professionals can positively relate to African American families.

- A two-part, two-day seminar on the design and implementation of home-based services. Part one is offered for administrators and supervisors and entails training for the design and implementation of HBS. Part two is offered for direct service staff and includes "how to's" for counselors.

- A two-part substance abuse seminar which focuses on the historical perspectives of the African American experience as they relate to pathology and on the importance of cultural sensitivity in the design and implementation of viable treatment options for African American drug abusers and their families.

- A workshop on sexually transmitted diseases (STD) and the black family, which is designed to assist professionals in providing an array of education and prevention methods aimed at reducing STD among "at risk" minorities.

- A half-day workshop on the proliferation of violence in the black community, which focuses on the African American experience as it relates to violence, on whether violence is deviant behavior, and on how to use cultural sensitivity to African American violence as a therapeutic tool.

- A half-day workshop on effective communication which is designed to improve workers' ability to support African American clients through learning about culturally sensitive issues as they impact African American speech patterns.

BFDI believes training other provider organizations will help to expand its capacity to provide culturally competent services to the African American family. Indeed, one of BFDI's objectives for the future is to establish itself as a training facility for African American professionals/community.

Understanding the dynamics of difference

In implementing programs, BFDI takes into consideration the concept of the dynamics of difference which must be understood if one is to provide culturally competent services to African American families. BFDI is aware that African Americans, as is the case with other minority group members, bring culturally prescribed patterns of communication and problem solving to cross-cultural interactions. Because of this, BFDI staff have chosen to implement some culturally specific services and strategies (e.g., cultural competence training, staffing patterns) in order to minimize misinterpretation and misjudgment which might otherwise occur in cross-cultural interactions. However, in a competitive political climate, when funding for human services programs is limited, it becomes necessary for BFDI to "sell" funders on the need for culturally specific services and strategies. This task has, at times, been difficult, especially when funds are in short supply. The board, however, has been effective in its advocacy efforts so that BFDI services remain a priority in the political arena. Additionally, BFDI continues to receive support from local and state human service agencies. Family preservation is a priority in the State of Michigan.

Minority participation at all organizational levels

There are strong indications that BFDI adheres to the culturally competent principle that minority participation is essential in planning, governing, administering, and evaluating the development and implementation of services. The staffing patterns, membership on the governance board, clients and families served, needs assessment and client satisfaction surveys are all testimony to the importance which BFDI places on the value of minority participation in its service delivery system.

The BFDI board of directors is an excellent example of a minority governing board which provides leadership and shapes policy for service delivery to a minority population/community. The board is composed of 24 African American members, including 9 males and 15 females. They represent a broad and diverse cross section of Detroit's African American community, including attorneys, a banker, ministers, agency executives, legislators, police department personnel, judges, educators, physicians, social workers, and ordinary citizens. A slot on the board is reserved for a representative from the Detroit Association of Black Social Workers – the organization that established BFDI. The Association of Black Social Workers continues to serve as an advocacy group for BFDI.

The board of directors sets policy for the agency, examines compliance with contracts, assumes fiscal accountability, hires the executive director, and evaluates her performance. Additionally, board members get involved in the political arena by advocating for the interest of BFDI with elected officials in the state capitol in Lansing. They also meet with state agency executives as appropriate. The board sees itself as a "hands on" board that is very committed to the African American community. It is organized into a number of committees, including public relations, program, finance, social issues, resource development, and long range planning.

The chair of the Program Committee indicated that, as part of the board's oversight responsibility, her committee reviews evaluations done by the community, reviews reports to contractors, and evaluates client satisfaction survey reports. The Long Range Planning Committee, through a Board Retreat Process, reviews and approves the mission of BFDI, sets policy direction, and formulates long-range goals. The board's objectives as outlined at a recent board retreat were to utilize board resources to enhance service delivery; to expand facilities commensurate with funding, programming, and staffing levels; to expand board committee activities through task force groups including non-board members; and to develop and expand advocacy strategies.

The president of the board had been in the banking industry for 16 years, thought that she had skills and should give back to the community. She sees her responsibility as a board member to provide leadership in the policymaking area, and to oversee the corporate resources of BFDI.

Because BFDI was established by a local professional African American organization and bases its policies and programs on community needs, BFDI was, from the onset, sanctioned by the African American community of Detroit. This means that BFDI has grass roots support and thus is able to generate a political climate which is conducive to providing effective services to African American families.

ROBERTO CLEMENTE FAMILY GUIDANCE CENTER
New York, New York

In its work with Hispanic adolescents, the Roberto Clemente Family Guidance Center sees the family as the "primary and preferred point of intervention." The center values language differences and responds to the issues of the migratory experience which many of its clients bring with them.

Brief History and Identification of Agency

The Roberto Clemente Family Guidance Center (Clemente Center) is an outgrowth of a New York State Office of Mental Health (OMH) demonstration project focused on mental health services for ethnic minority populations. The OMH demonstration projects, funded in 1983, have now been mainstreamed into the New York City mental health system. The Clemente Center has continued since the demonstration phase ended four years ago. It is now an outpatient clinic of the Gouverneur Hospital's Department of Psychiatry and offers a variety of outpatient mental health and educational interventions to Latino/Hispanic families and children. The Clemente Center is named after Roberto Clemente, a Puerto Rican who was one of the greatest American major league baseball players. In the classification of agencies, the Clemente Center is an example of a mainstream agency (Gouverneur) supporting services by minorities within minority communities.

Community Description

The Clemente Center is located in a storefront on the Lower East Side of Manhattan. The community is predominantly peopled by low-income Latino/Hispanic and African American families, although there has been a recent influx of Asian Americans in the area. The center's target population is the Latino/Hispanic groups in the area, who are mostly poor Puerto Rican migrants. The center is located in an area where more than half the buildings are abandoned or burnt out. A large part of the community consists of low-income housing projects operated and owned by the city. The area also has one of the highest proportions of families with the lowest income in the city, and an unemployment rate of 60 percent.

Target Population

The target population for the Clemente Center are those Latino/Hispanic families and individuals residing on the Lower East Side of Manhattan. Although this is the area from which most of the clients are drawn, referrals of Puerto Rican clients come from all the New York City boroughs and the suburbs. Often clients are referred when there is no bilingual staff at a given facility and the client speaks Spanish only. Most of the families are low income and eligible for Medicaid reimbursement. In addition, many of the clients are first- or second-generation migrants from Puerto Rico.

The center has the capacity to treat up to 50 children and their families at any given point in time. The children served are between the ages of 4 and 18 years of age; approximately 60 percent are female and 40 percent are male. Ninety-five percent of the clients are Latino/Hispanic, 3 percent are African American, and 2 percent are white. Fifty-three percent of the clients have not completed high school and 63 percent have had no prior contact with mental health care. About 43 percent of the adult clients who attend the center do not speak English.

In more recent years, the Clemente Center has noted an increase in the number of mixed marriages among its clients. Such families often present with marital difficulties and conflicts related to raising children. The center has also begun to receive a large number of referrals for Latino/Hispanic children who have been placed in foster care. Again, this presents some clinical challenges since many of the foster parents are non-Hispanic. The other group or family constellation that appears to be increasing are households with grandmothers and children where the parent has died of AIDS or is a substance abuser.

Program Philosophy and Goals

The program philosophy at the Clemente Center is one that understands behavior within its family and ecological context. When viewed in a social, cultural, and political context, the mental health problems for Puerto Ricans differ substantially from those of their white, mainstream American counterparts. These differences are based on social and environmental variables, acculturation, migration patterns, and values. The center has developed a program philosophy that addresses these differences and incorporates Puerto Rican conceptualizations into the understanding of mental health problems and the therapeutic interventions utilized to resolve them.

This acculturation model, therefore, emphasizes the need for providers to become familiar with the values of the Puerto Rican culture. This model also notes that within the Puerto Rican culture, values may vary in relation to social class and generational differences. The process of migration and acculturation is strongly linked to psychological stress and these are the major issues addressed by the Clemente Center.

Given this philosophic viewpoint, the major goal of the mental health interventions is the family's social and cultural integration. This means that their identity, belief system, feelings of self, personal integration, family integration, and community integration must be achieved. Therefore, all Clemente Center interventions are designed to:

- provide an opportunity for poor and Latino/Hispanic families to address and acknowledge mental health stresses in a culturally-syntonic environment;
- provide a supportive network and guidance to clients who are experiencing loss and confusion due to the migratory experience and/or conflicts with the values and customs of the United States;

- provide the necessary information and education that will allow the cultural transition to be less disruptive and stressful; and
- provide a supportive therapeutic environment which allows clients to express their beliefs without having negative interpretations placed on them.

The Clemente Center has actualized these goals through the use of bilingual/bicultural staff and a framework for therapeutic intervention that recognizes the importance of values and beliefs, especially when the client or family is experiencing the impact of migration and acculturation.

Services

The Clemente Center offers a full range of outpatient services to the client population. These include: diagnostic assessments, individual psychotherapy for children and adults, family therapy, group therapy, advocacy, and a continuing treatment program (psychiatric day hospital for adults).

Although these are traditional services, the approach and content of these services is very different and reflects the tailoring needed to address the issues of poor and lower-class Hispanics. The overall treatment approach is an ecological systems model, with emphasis placed on the family.

Funding

It costs approximately $1 million annually to operate the Clemente Center. It is fully funded by the New York City Health and Hospitals Corporation (H.H.C.) through a deficit funding arrangement. This means that H.H.C. pays the balance of the difference between the revenues generated by the Clemente Center and the costs of operation. The Clemente Center receives city and Medicaid reimbursement, Medicare, private insurance, and self-pay. It operates with the sliding fee scale structure for Gouverneur Hospital.

Program Efficacy

During the first three years of the program, extensive evaluations were conducted by the state OMH. The reports from these evaluations basically gave a sense of the client population, a breakdown by age and sex, and other demographic characteristics. The evaluators also found that the services were used and there was a high level of satisfaction from clients.

Since those initial evaluations, the center has not had the time or staff to conduct program evaluation or more formalized assessments of the program's effectiveness. The center staff would like to be able to conduct an ongoing program evaluation. They would also like to collect follow-up data on clients for a period after services are terminated.

The Gouverneur Hospital distributes a quarterly questionnaire on patient satisfaction for all ambulatory sites. Patient representatives tally the results of interviews with patients and observations about: (1) arrival time, (2) patient status, (3) waiting time, (4) instructions for care

given, (5) comprehension of these instructions by the patient, and (6) staff attitudes. The Clemente Center has shown high levels of client satisfaction. The most important measure of client satisfaction, however, is the fact that the majority of clients referred to the center now come from former clients or families. This indicates a large acceptance and approval of the services received at the center.

Cultural Competence Principles

Acknowledgement of unique issues of bicultural/bilingual status

The Clemente Center grew out of a demonstration focused on improving access and acceptability of mental health services to Latino/Hispanic populations in New York, primarily Puerto Ricans. When viewed in a social, cultural, and political context, the mental health problems for Puerto Ricans and other Latinos/Hispanics differ substantially from those of their white, mainstream American counterparts. These differences are based on social and environmental variables, acculturation, migration patterns, and values.

Due to the bicultural and bilingual status of Latinos/Hispanics, they encounter many problems when trying to gain access to mental health and other services. First, therapists in mental health centers are often not culturally sensitive or culturally competent, therefore they attempt to persuade clients to work outside their belief systems. Second, the centers to which they are referred are not culturally syntonic, that is the values found in these centers are not similar to those held by the clients. The Clemente Center has addressed these issues in several ways.

Of major importance, the Clemente Center hires only bilingual/bicultural staff. Ability to receive services in one's own language immediately increases access. Further, with bicultural staff the values and beliefs of a group can be more easily understood and incorporated into the development of a therapeutic alliance in the treatment process. Utilizing a framework that recognizes the importance of values and beliefs, especially when the client or family is experiencing the impact of migration and acculturation, also increases the acceptability of services.

The Clemente Center has also increased accessibility to services through its geographic location. Although affiliated with a hospital, the center is not located at the hospital but in the community. Thus, the center can enjoy the rich resources of the hospital but be community based. To increase community access, the location of the center in the Latino/Hispanic community is very important. The physical decor of the center also reflects the community it serves. Maps of Caribbean countries and Central and South America as well as Latino/Hispanic posters and community-donated art work reflecting the diversity and richness of Latino/Hispanic cultures adorn its walls. All pictures at the center convey a cultural message about the clients served or the community which surrounds the center. The literature in the waiting room is in both Spanish and English. A rack displays magazines and literature on immigration and minimum wage laws, as well as upcoming events in the community related to housing and community development. These and other examples based on a knowledge of the culture have established

the Clemente Center as an important resource for the Latino/Hispanic population in New York City.

Incorporation of cultural knowledge/preferred choices in practice and policymaking

One of the major strengths of the Clemente Center is the incorporation of knowledge about culture and preferred choices into the practice, therapeutic interventions, and policies of the center. The Clemente program philosophy is predicated on the major assumption that migration and acculturation, especially into another culture, create severe emotional distress and disorientation. According to Inclan and Herron (1989), in a chapter on Puerto Rican adolescents included in *Children of Color*, this experience creates four clashes:

- The *cultural clash* has its roots in the political relationship between Puerto Rico and the United States. When citizenship was conferred on Puerto Ricans, the questions of cultural and political identity arose. Although Puerto Ricans are citizens, they have no congressional representatives, speak a different language, and are targets of constant racial and political discrimination. For adolescents, the juxtaposition of these two contrasting cultures makes self-definition a difficult process.

- The *generational clash* is reflected in the schism between first-generation parents and their offspring. Moral standards and cultural practices of the parent generation differ greatly from those of American adolescents.

- The *socioeconomic clash* refers to the contiguity of wealthy, affluent, mainstream communities and poor, disadvantaged ghetto communities. These two types of communities coexist and compete as a framework for identity and success with the mainstream culture, which often reflects the aspirations of first-generation parents. The question for Puerto Rican adolescents becomes: Should I aim for the mainstream world as a framework for success? The choice is not an easy one for the adolescent who is cognizant of the barriers to success for Puerto Ricans in mainstream society.

- The fourth clash involves the *process of individual development*. Adolescence, as a discrete developmental stage, is a relatively recent concept and is characteristic of a modern industrial society. However, for the agricultural economy of Puerto Rico, an apprenticeship model of passage into adulthood is functional and adaptive. Apprenticeship models of adolescence foster family cohesion and devalue individuality. This creates major family problems for Puerto Rican adolescents growing up in American society who have families with a different conceptualization of the role and responsibilities of adolescence.

Thus, Clemente Center staff find that there are several presenting problems that are fairly common among Latino/Hispanic adolescents and their families. These include:

- Those experiencing adaptational problems due to migration, which can include isolation, feelings of loss and depression, parent-child conflicts, lack of support networks, and lack of knowledge about how the U.S. system operates.

- Those experiencing marital problems or sex roles/identification confusion due to conflicting values between the old culture and the new one. Again, this is usually a secondary problem associated with the migratory experience.
- Children experiencing problems at school, in the home, or who come to the attention of various social agencies.
- Adolescents experiencing real conflict and inability to solidify identity and role issues. They often experience these conflicts through problems with parents, since cultural issues are very prominent.

Therefore, the conceptual approach to treatment used by Clemente Center staff recognizes the critical importance that culture and value orientations have in the behavior and belief systems of groups. Using the predominant Anglo middle-class-value orientation as outlined by Spiegel and Kluckholm (1954), Inclan describes the differences between first generation Puerto Ricans and mainstream whites along the four value dimensions: activity, relational, person-nature, and basic human nature.

Values are also influenced by the migratory experience of the group. For example, first generation migrants tend to uphold their culture of origin and its values when in the new host culture. In the new host environment, these migrants experience culture shock to which they react by attempting to make the family a tighter unit and by holding more strongly to those values. The second and third generations, starting in adolescence and preadolescence, must cope with and adapt to the language, culture, and values of the new environment. These constitute groundbreaking efforts where stress, failure, and defeat are not uncommon. Rather than attempt to change these values and belief systems, the center embraces and engages with clients around these values, thus allowing the development of therapeutic alliances and relationships that keep clients in therapy and assist them in redefining their problems and solutions.

Family as the primary system of support and intervention

The Clemente Center strongly adheres to the culturally competent principle that the "family" as defined by the culture is the primary and preferred point of intervention. The orientation to services at the Clemente Center is always from a family perspective. The dominant intervention model is an ecologically-based family therapy. This emphasis on family versus the individual is critical to maintaining the values and belief system of the Latino/Hispanic culture. Women and children are not autonomous, independent beings but, rather, are defined by their roles and responsibilities to the family system. Although this may have eroded somewhat in the adaptation to American society, it is still a fundamental principle when intervening with Latino/Hispanic peoples.

When a referral is made to the Clemente Center to work with a Latino/Hispanic child, the clinician meets with the child and other family members to understand the presenting problems. There are also consultations with extended family members and persons in the family's support network. It is very important that significant males be included in the initial process, since their sanction of treatment is extremely important. It is also important to allow the clients to define

"family" in a way that makes sense to them. Often, this includes siblings, cousins, grandparents, friends, and others who provide support to the individual or family.

The whole goal of the therapeutic interventions at the Clemente Center is to stabilize, strengthen, and empower Latino/Hispanic families. All of the intervention is family-focused, stressing and validating the importance and value of family in the Latino/Hispanic culture. Although mainstream mental health theories often believe that adolescence can, and often should, be viewed as a period of individuation from family, Clemente Center staff believe that it is critical to treat poor Puerto Rican adolescents within the context of their families. As noted earlier, the Puerto Rican family system views adolescence from an "apprenticeship" model, which differs substantially from the "individuation" model of American society.

Therefore, Clemente Center therapists have found the technique of "cultural reframe" very useful. In this technique, the experience or demand that a parent or adolescent makes is analyzed in relation to the cultural values that constitute the background for the demand or expectation. For example, a mother's request that her daughter interact less frequently with peers is viewed as expressing a value that the family takes priority over the individual. The adolescent's demand for greater peer contact is viewed as expressing a value of individuality over the family. Each value is understood to be functional, or adaptive, within its social context. Cultural reframe allows the therapist to shift the blame from the person to the acculturation process, which places different demands on the parent and adolescent generations. Once the problem is understood in the context of acculturation, the therapist may proceed to the next stage of therapy, which involves presenting an objective and impartial model for family progression through the stages of adolescence. This model is based on the process of exchange and negotiation between parent and adolescent for greater freedom, trust, and responsibility.

There are certain other aspects of the acculturation process and the impact on family relationships that have proven significant in work with these families. First, because first-generation parents have limited ability to serve as a bridge between the old and new cultures, sibling relationships have been found to be very important in poor Puerto Rican migrant families. This is an underutilized resource in family therapy in general, and in the therapy of minority adolescents in particular. Secondly, work with poor migrant Puerto Rican families suggests that traditional approaches to the question of hierarchy within the family be reviewed. In these families, the adolescent often has a greater mastery of the language, behaviors, and social mores of the new culture. Some adolescents, owing to their level of acculturation, social achievement, or developmental maturity, are able to assume executive or other functional leadership roles within the family. The clinical criterion to be observed in such situations is whether this role is assumed with the implicit sanction of the parents or in a manner that undermines parental status and role, thus generating family dysfunction and psychopathology.

Importance of cultural assessments

Culturally sensitive assessments are often utilized by the Clemente Center. These assessments revolve around an understanding of relevant sociocultural issues and entail review of the four "clashes" noted earlier and the adolescent's place along the continuum. The staff believe that cultural assessments must occur if therapeutic interventions are to be effective. Other

family members may also be assessed, utilizing knowledge of their history and migration pattern. Inclan (1989) has developed a culturally specific tool, the Puerto Rican Acculturation Measure, to look at acculturation in terms of the acquired knowledge of culturally specific items common to both United States and Puerto Rican culture.

Formally, the center utilizes the same intake packet as that of Gouverneur Hospital, and for each case a DSM-III-R diagnosis must be given. Many times, however, the diagnosis is deferred and the problems are noted as child-related family issues. Unlike many traditional clinics, the Clemente Center does not encourage psychological testing of children. The center has found that many Latino/Hispanic children have been over tested by school systems and other clinicians. Further, the test results tend to be extremely controversial since they are not administered in Spanish and often reflect the biases of the white American mainstream society. Until culturally sensitive tests are in place, Clemente staff depend more on family interviews and family assessments.

Concept of responsive services

The Clemente Center meets the culturally competent principle of responsive services matched to the population being served through offering a culturally syntonic environment. This means that services show a respect for language and a respect for the values of the family. The Clemente Center requires that all staff be bilingual/bicultural and that services be offered in the language that the client finds most comfortable. Oftentimes, clients switch back and forth between English and Spanish, depending on the subject matter being discussed.

Since cultural beliefs cannot be mandated, the emergence of a culturally sensitive treatment program must come from within the structure itself. For example, the structure of the center's program contains the following features that are representative of and responsive to the culture of the clients: acceptance of spiritism and other natural helpers as an avenue to express conflict, acceptance and availability of food, and an understanding of the migratory experience and the acculturation process on mental health.

The center provides a supportive therapeutic environment which allows clients to express their beliefs without having negative interpretations placed on them. For example, a belief in "spiritism" is very common among clients. Instead of seeing this as something that must be shifted, a therapist, working within the described philosophical framework, would use the expression of these beliefs as a starting point for therapy. The authenticity of the client's belief system is never questioned. Spiritism is interpreted as a culturally specific vernacular which provides clients with an avenue for articulating their conflicts. It is discussed openly in sessions by clients without fear of the therapists imposing diagnoses or their own interpretations on these belief systems. The acceptability of spiritism creates an atmosphere which provides comfort and acceptance and encourages clients to attend therapy and express their own experiences in a way that is culturally familiar.

Food is also an integral part of the Latino/Hispanic culture. When one pays a visit to an Latino/Hispanic friend or family, it is often expected that the guest will be offered something to eat. Turning down food in this culture is often considered impolite and rude. Food provides a

means of connecting and welcoming others into one's home. Food is present at most activities at the Clemente Center. It is an integral part of administrative meetings, staff meetings, and therapy sessions. By allowing the introduction of food, the Clemente Center enables clients to find acceptance and bonding in a setting where cultural values are similar to their own.

Finally, although traditional modes of psychotherapy are utilized – individual, family, and group – the content and goals of treatment are very different. The goals of family therapy, which is the most utilized approach, have been discussed previously. Group therapy has also come to be viewed as a critical service offered by the center. The Clemente Center's group therapy program adheres to an educational psychotherapy model, based on the assumption that migrant group populations need information and education as well as therapy.

For example, the educational psychotherapy group for adolescents is a time-limited group experience focused on particular themes such as: family and independence, sexuality, cultural identity, school issues, peers and peer pressure, and racism and discrimination. The ten-session educational psychotherapy group experience is designed to be a complete program in itself, however it may also serve as an introduction to and preparation for continued therapy.

Other groups have also developed to address the concerns of many Latino/Hispanic women. For example, there is a mid-life crisis group for women experiencing the "empty nest" syndrome when their children leave the home. There are also groups for single parents and those that address sex roles and orientations in adjusting to American society. Members of most of the women's groups are first-generation females. The Clemente Center is also beginning to develop groups to address the increasing number of Latinos/Hispanics who are HIV-positive and/or family members who are struggling with the AIDS of a family member.

Individual psychotherapy for Latino/Hispanic adolescents reflects an awareness of the four clashes discussed earlier. The goal of this treatment is the integration of the old with the new in such a manner that the adolescent remains productive and develops a positive self-identity and self-concept. Therapy is also geared towards resolution of the family conflict in a way that fosters family cohesion and allows for the integration of new values into the life of the adolescent.

Individual psychotherapy for parents is often centered around the common themes of loss and depression. According to clinic staff, depression is the most frequently cited reason for clients to come to the center. Depression is viewed as being related to the sense of loss which accompanies migration, a feeling which can last nine to ten years after migration has occurred and is associated with past and present experiences of poverty, such as not being able to find adequate housing or jobs.

Working with natural, informal support systems

The Clemente Center staff recognize and acknowledge that many of the clients also utilize the more informal network of natural helpers in the Latino/Hispanic community. There are no professionals at the center to provide spiritist consultation, but information on spiritism is available through one of the therapists and other center staff.

In the ecological world view espoused by the Clemente Center, the community is used to develop support networks for clients and families. For example, group therapy is viewed by the women as extremely supportive and, over time, the group members have become a support network for each other. They keep in contact with each other outside the group and care for one another when there is illness or other difficulties. These groups tend to be ongoing and clients have found it very difficult to terminate their participation.

Since the center views itself as an integral part of the community, substantial use is made of informal networks. The center has an outreach coordinator who is responsible for developing and maintaining liaisons with other agencies within the community. In addition, therapists at the center have a set of agencies for which they have networking responsibility. These networking activities include the schools, rape and incest agencies, hospitals and ambulatory clinics, preventive and foster care agencies, and churches.

The Clemente Center has also undertaken special projects from time to time to enhance the well-being of the community. At the time of the site visit, the center was in discussions with local Latino/Hispanic artists about the development of a mural depicting scenes and portraits of heroes from the extensive Latino/Hispanic history. This mural would be painted on the outside of the center, thus brightening up the neighborhood that has many abandoned and boarded-up buildings and providing an opportunity for local artists to participate in the project.

Provision of an integrated network of services

An integrated network of services is provided at the Clemente Center through staff functioning as case managers, through a focus on acquiring knowledge and interacting with other community resources, and through building collaborative relationships. As noted earlier, the Clemente Center has a strong community orientation. There has been extensive and impressive outreach resulting in linkages being forged with community agencies and community issues. The center also includes community agency staff in its training activities.

Since it is an outpatient program in the Gouverneur Hospital system, the Clemente Center has strong linkages with this facility. In addition, the center has cultivated and developed very strong linkages, primarily through training activities, with universities, colleges, and other minority-focused programs in the city. These include:

- participation in the Lower East Side Consortium of Mental Health Agencies, through which work is coordinated with all area facilities;
- participation on the Gouverneur Community Advisory Board, which includes city-wide planning and information dissemination through the Mayor's Office on Hispanic Affairs; and
- coordination with the Minority Education Research and Training Institute at Metropolitan Hospital, of which the Clemente clinic director is a co-principal investigator.

Staffing patterns and ethnic composition

Due to its emphasis on the hiring of bilingual/bicultural staff, the Clemente Center is able to interact with all Latino/Hispanic clients, whether they are English speaking or not. Since there are usually some members in migrant families that are bilingual, and crucial others who are monolingual (usually parents, grandparents, and other relatives), most mental health centers and programs are not able to utilize one of the most effective means of intervention – family therapy. The Clemente Center, on the other hand, is not only able to intervene with the whole family but is also able to support and validate the great importance and significance that family has in Latino/Hispanic cultures.

As noted, all staff at the Clemente Center are bilingual and bicultural. Many of the staff are first- or second-generation migrants themselves, and have a first-hand experience or knowledge of the issues that arise with such statuses. The current staff consists of 11.5 full-time staff, including the director, an administrative assistant, two office associates, two social work supervisors, two social workers, three case workers, one psychologist, and one and a half psychiatrists. The office associates and caseworkers are paraprofessionals. The staff is 60 percent female and 40 percent male. Many of the staff are Puerto Rican, but there are also staff from Cuba, Venezuela, Nicaragua, Brazil, and the Dominican Republic.

The center is also a major training site for several universities in the New York City area. Annually, the center supports three social work interns and five psychology interns/externs. In addition, psychiatric residents from various medical schools may also complete a rotation at the clinic. All of the interns have been Latino/Hispanic students.

The fact that all staff at the Clemente Center are bilingual/bicultural may be even more important than the strong family orientation. Not only does this eradicate language barriers, but this requirement has allowed the center to maintain a quality control in relation to staff, since all are empathetic to the client pool. Also, the bicultural staffing has saved the center from having to deal with two waiting lists and negative intra-group dynamics. It has also built a high level of staff cohesiveness since clients can see any clinician.

The therapists also have an interest in and knowledge of the predominant values and beliefs of the client population. As first- or second-generation migrants, they have first-hand knowledge of the issues that arise with such statuses. Therapists who work within this framework are encouraged to be active in relation to their clients, not only as role models but also as bridges between the familiar and the new. Thus, therapists are not only professionals, but they must also be educators, advisers, and advocates who assist clients in dealing with individuals and agencies.

The staff is organized ecologically rather than having a more traditional hierarchical structure in which certain disciplines perform certain functions. Rather, the center uses a family practitioner model. With the exception of psychiatrists, all therapists are responsible for the full care of a client or family (i.e., outreach, therapy, and advocacy). This means that there are no functionally determined roles. However, the center does observe a hierarchy in terms of supervisory structures and in pay scales.

The staff functions as a close-knit family. When staff members arrive in the morning, they often congregate in the staff lounge to talk in Spanish about the news in the United States and abroad. These morning rituals include administrative staff, treatment staff, and student interns. Food is always present. Since the staff is often busy all day, this provides an opportunity for them to relate to each other in a less rushed and more personal manner, helping to solidify staff cohesiveness and camaraderie.

The Clemente Center utilizes both professional and paraprofessional staff. The paraprofessionals on staff, especially the office associates, play key roles in the therapeutic process at Clemente. The office associates obtain initial information from telephone calls. Since they are also receptionists, clients often open up to them in their initial contact with the center. The office associates are courteous, friendly, and available to clients who call on the phone as well as those that walk in or come for scheduled appointments. They are viewed as very supportive to the clients. In their informal interactions with the clients, they are often privy to confidential or other pertinent information that has a direct bearing on some of the presented mental health issues. Since they are aware of psychotherapeutic issues, the office associates are able to share their information and observations with the therapists at the center.

The use of paraprofessionals also illustrates another culturally sensitive component of the Clemente Center program: the legitimation of paraprofessional staff. Given the scarcity of trained minority mental health professionals, the center has fashioned an approach to utilizing human resources within the community in a non-exploitative manner. Extensive training is provided to paraprofessional staff. However, without the components offered by Clemente – training, career ladder opportunities, and proper compensation – use of paraprofessionals becomes highly controversial. In fact, the center sees part of its mission as the support and development of paraprofessionals. Several of its staff have returned to school and received higher education degrees. It should be noted that, even with paraprofessionals, there is a great need for Latino/Hispanic professionals. Overreliance on paraprofessionals does not lend itself to the quality of services needed to address the serious mental health problems of poor and disenfranchised minority groups.

Cultural competence training

The Clemente Center places great emphasis on staff training; in fact, inservice training focused on cultural issues is required. The director conducts seminars with students and new staff. The seminars are formal and organized. In the beginning weeks, the seminars are mostly didactic lectures and discussions. However, during the course of the year the seminars tend to become more focused on clinical interventions and are augmented through videotaped and live interviews with families. All therapists are required to learn how to operate the videotape equipment and often utilize it to tape some of their clients, with their permission. Thus, the center has an extensive videotape library for illustrating therapy techniques with Latino/Hispanic families. In addition, all staff receive training through weekly individual and group supervision.

The seminars taught by the director have been developed into a curriculum outline that could be a model for other agencies and organizations interested in developing cultural awareness and some competencies in their treatment staff. This curriculum outline, focused on

understanding Latino/Hispanic families, consists of 18 modules that are presented through readings, lectures, group discussions, and, often, videotaped presentations. Each module has a stated goal and objective. Examples of some of the modules are as follows:

Module 2: Ecological vs. Family Systems vs. Culturalist Perspectives
Module 3: Differences Among Hispanic Ethnic Groups
Module 4: The Process of Migration
Module 5: Historical Context of Puerto Rican Families
Module 9: Values Orientation and Family Therapy
Module 12: Influence of Religion in Puerto Rican and Hispanic Families

Feedback and follow-up observation suggests that even though the curriculum is Hispánic-focused, the overall lessons are applicable and useful for working with other poor, minority groups. This suggests that, more important than the content learned, the training influences attitudes and "person-of-the-therapist" considerations and promotes an ecological thinking mode that is transferable to other settings and population groups.

Understanding the dynamics of difference

Since the clients of the Clemente Center are bilingual and bicultural, and there are few resources available to address their needs, cross-cultural differences in approach and perspectives often occur. In fact, the Clemente Center was set up to minimize the disruptive impact of cultural conflicts so that the treatment process could be facilitated. However, there are two recurring situations which illustrate the dynamics of difference.

One situation occurs with the referral and utilization of other community agencies and resources. Many of these agencies have few, if any, bilingual/bicultural personnel. Therefore, if staff members refer clients to their services, they often have to act as interpreters. The center has also found that it receives many inappropriate referrals because of the language barriers and lack of bilingual staff in other agencies. Since agencies know that Clemente has Spanish-speaking staff, they refer clients to them who have legal, welfare, or physical health problems. Again, when this occurs Clemente staff feel a strong responsibility to ensure that the family finally gets to the appropriate agency, but this also impinges upon limited staff time available for providing direct services.

The other example of the dynamics of difference occurs when there are conflicts between the mainstream institution (Gouverneur Hospital) and Clemente. Since the center is located within a large organization, there are many layers of bureaucracy that have to be dealt with before an action can be taken. There are occasions when the policies established by the hospital conflict or create obstacles to the therapeutic approach developed by the center. For instance, due to Gouverneur policies and liability issues, patients may not be able to participate in a community garden project. This is a proposal by the center to turn an adjacent lot filled with glass and debris into a neighborhood playground for the children and into a garden for adults. The center proposed that patients in its Continuing Treatment Program work with some community volunteers on this project. There are also liability issues for staff delivering services off site (i.e.,

in a school or other community agency). These types of policies and concerns are often contrary to the best interests of the clients.

Minority participation at all organizational levels

Since all of the staff at the Clemente Center are Latino/Hispanic, the agency meets the principle of inclusion of minorities in the planning, administration, delivery, and evaluation of services.

The external policies are established by the Gouverneur Hospital's Community Advisory Board. There are 27 members of the Board. It is an extremely energetic and lively board, and includes many different segments of the Lower East Side community -- Italians, Latinos/Hispanics, African Americans, and Chinese. The board also has ample representation and linkages with city government officials as well as state and city legislators. Members of the board are appointed by the New York City Health and Hospitals Corporation.

During the site visit it was obvious that the board members were very familiar with the director of the Clemente Center and with the clientele that it serves. The board has begun looking at the Clemente Center as a prototype for services that might be delivered to the growing Asian population and to other Spanish-speaking immigrants that are resettling on the Lower East Side.

Support of self-determination for the broader minority community

It is the philosophy of the Clemente Center that the agency must not only be an integral part of the community, but must also seek to have impact at the community level as well as at the family level. This is because the psychological distress of poor, minority families is intricately and intimately connected with the environment in which they reside. The community permeates, and is sometimes inseparable from, the mental health and well-being of its inhabitants. Therefore, the center is located in the heart of the Latino/Hispanic community on the Lower East Side.

Further, the center recognizes and understands the impact of social and environmental factors on the psyche of oppressed minority groups. The Clemente Center staff recognize that social change advocacy, as well as the delivery of concrete services, are necessary components of the services to be provided to poor, minority clients. Therefore, although the center is established as a mental health clinic, it provides services that go beyond this sphere. Services include advocacy and assisting clients to obtain appropriate housing and financial help, for example. Also, the services offered to the migrant attempt to remedy or mitigate environmental factors which are believed to disrupt mental health.

THE INDIAN HEALTH BOARD OF MINNEAPOLIS, INC.
THE SOARING EAGLES PROGRAM
Minneapolis, Minnesota

The Soaring Eagles Program focuses its energies on prevention and proactive strategies to aid children already exposed to the destructive forces of poverty and alcoholism. This program is geared to building self-esteem, self-worth, and creating a re-valuing of cultural identity through education, recreation activities, and a deemphasis on the use of alcohol as a normal part of life's routine. This program reacquaints American Indian children and parents with the values and rituals of culture by highlighting cultural values and strengths.

Brief History and Identification of Agency

In 1971, the Indian Health Board of Minneapolis, Inc. (IHB) was formed. It is a minority-owned agency serving a minority community. The IHB was developed to provide low cost, comprehensive community health services to medically indigent and underserved American Indians in a culturally sensitive atmosphere. The IHB began with a dental clinic in 1972 and expanded to include a variety of medical services in 1974. Mental health services were added in 1978.

In 1980, the IHB executive director examined whether the services offered by the agency had any impact on improving the health care status of American Indians in Minneapolis. She found that the IHB had made only minor changes in the population's health status. She concluded that the two most critical health problems of the American Indian community were poverty and alcoholism. Although all of the existing programs and clinics were addressing these issues indirectly and in a maintenance-type manner, if the cycle were really to be broken the emphasis would have to be placed on prevention efforts focused on American Indian children.

In 1984, the IHB established the Social Center for Youth and Families. Its mission was to promote social changes to reduce the cyclical nature of poverty and alcoholism in Indian communities by providing a supportive social environment in which leadership potential and positive growth of American Indian youth could be fostered. Although it is highly unusual for a health clinic to have a social center, this center became one of the few viable community organizations to address the needs of American Indian children and families in a proactive manner.

The social center started with a drop-in program. This program offered support to individuals and families trying to maintain an alcohol-free lifestyle. In 1985, the Soaring Eagles Program was established. This program is an American Indian Youth Prevention and Leadership Development Program.

Community Description

The Phillips community, in which the IHB is located, is in south Minneapolis and had a 1980 census population of 17,413 persons. Population demographics at that time were as follows: 69 percent white, 18 percent American Indian, 8 percent African American, 3 percent Latino/Hispanic, and 1 percent Asian/Pacific Islander. However, 86 percent of those utilizing IHB services are American Indian. These clients come from 69 federally recognized tribes; the predominant tribal groups are the Chippewa and the Sioux.

Fifty percent of the American Indian families in the Phillips area are below the poverty level. The community also has a large proportion of female-headed households; over 80 percent of children are born out of wedlock. There are high rates of teenage pregnancy and children born with Fetal Alcohol Syndrome – a condition that is associated with a high level of alcohol abuse among pregnant women. Due to the prevalence of alcoholism, there are high levels of domestic violence, child abuse, and neglect. It also exacerbates school failure and drop-out rates, which are extremely high.

Another characteristic of the Indian population is a high level of mobility. Indian families move back and forth between the city and reservations. Almost 30 percent of the population is always in transition. Although many Indian children are born in the urban area, they are socially isolated from the larger urban community due to racism, poverty, and the lack of access to other areas in the city. Thus, the urban area in which many of these children reside is very similar to the reservations in terms of the level of isolation from the mainstream.

Target Population

The Soaring Eagles Program serves American Indian children between the ages of 3 and 20. The target population is high-risk children who: are from low-income families, have a history of substance abuse in the home, have a high incidence of depression, are likely to be high school drop-outs, and have families that are likely to be on public assistance. These children are also at high risk of social isolation, poor self-esteem, and abuse/neglect. The youth who are admitted to the Soaring Eagles Program are called "members" rather than "clients," thus denoting the concept of privilege rather than treatment.

All American Indian children in Minneapolis are eligible for the Soaring Eagles Program. However, the majority of children come from the Phillips community. The program currently serves almost 200 youth. In total numbers, youth are equally divided between boys and girls. The only youth that are ineligible for the program are those that have already dropped out of school or those who are actively involved in gang activities.

Program Philosophy and Goals

The philosophy of the Soaring Eagles Program has grown out of a well-conceived and well-developed strategy by American Indians to enhance the leadership potential of their young and to reduce the dependence on alcohol and other chemicals in the Indian community. Using the

cultural values inherent in many American Indian tribes, the program seeks to build leadership through increased self-esteem and self-worth, knowledge of cultural values, development of a positive cultural identity, and development of a strong community support system for children. The program is predicated on prevention rather than on treatment or rehabilitation. Thus, there is a focus on Indian youth who have not yet been identified by other social service agencies as being "deviant" or "having problems."

The methods for accomplishing these goals place emphasis on: education; promotion of American Indian culture and values; abstinence from alcohol and other chemicals; provision of a supportive, therapeutic milieu; the availability of mental health services; and offering "fun" recreational activities. In very practical terms, the objectives of the program are to ensure that Indian children finish high school without becoming teenage parents, juvenile delinquents, or substance abusers. With a more informed, educated, healthy, and alcohol-free group of leaders, it is believed that the cycle of poverty and alcoholism that devastates the lives of so many Indians can finally be broken.

Services

The Soaring Eagles Program offers a wide variety of activities to children and their families. These include leadership development, cultural knowledge dissemination, educational sessions, recreational activities, cultural activities, educational support and tutoring, parent education and training, and transportation services. Particular emphasis is placed on academic achievement. All children receive a mental health assessment upon entering the program and annually thereafter (primarily for program evaluation purposes). Most services and activities have a cultural base and are conducted through age-related peer groups.

Funding

In the last fiscal year, the Soaring Eagles Program's operational costs were $390 thousand. Approximately $250 thousand of these funds came from federal grants, including the Office for Substance Abuse Prevention (OSAP). Twenty-five percent of the funding came from county and state government. The remainder came from private foundations and the United Way.

Program Efficacy

Since the Soaring Eagles Program has become a federal OSAP demonstration project, some level of program evaluation has been established. As stated earlier, mental health assessments, focused primarily on academic achievement, are administered to each child upon entering the program and annually thereafter. The program now has three years of assessment data on most of the children. The data show that most of the Soaring Eagles children test within the average range of achievement on standardized tests.

Mental health staff have found that most of the children maintain their level of academic achievement and show some progress. Most importantly, few are showing the usual academic lag noted for minority children around ages 10 to 13. This is an extremely positive finding.

There has been little attrition among the students except when the families move back to the reservations. Only one child has been asked to leave the program for involvement in gang activities. None of the Soaring Eagles children has dropped out of school. Only one teenager has become pregnant. There has been a decrease in the number of juvenile court incidents involving these youth. No Soaring Eagle is believed to have a major drug or alcohol problem, although staff is aware that there is some experimentation in that area. There have been only two suicide attempts among the Soaring Eagles members and there is a lower level of suicidal ideation than is found in the overall adolescent Indian population.

Another indication of the success of the program is that five members graduated from high school in the last year and they all are enrolled in higher education programs. Therefore, although staff see the program as still in its infancy, it is already having some impact on breaking the cycle of poverty and alcoholism for some of its members.

Cultural Competence Principles

Acknowledgement of unique issues of bicultural/bilingual status

The Soaring Eagles Program was expressly designed to address the unique issues associated with the bilingual/bicultural status of American Indian children in this country. Due to the racism and discrimination inherent in the American society, as well as the truncated living environment in which many Indian children dwell, they have poor self-concepts and identities. This is because they have limited opportunities and understanding of the rich Indian American culture. Their minority status has created a unique set of mental health issues to which the system must be equipped to respond. The impact of these stressors on American Indians is primarily manifested through an abuse of alcohol. This exacerbates poverty, isolation, and early death among Indian populations. The executive director of the IHB calls the introduction of alcohol to Indians as the "worst form of genocide ever perpetrated on a population."

It is the intent of the Soaring Eagles Program to expose American Indian children to another way of life and, thereby, increase their access to more positive lives and outcomes. Although many Indian people have adopted the "alcoholic" culture, Soaring Eagles wants youth to understand that this is not the Indian culture and very much contradicts the basic values and beliefs of Indian cultures. Therefore, through cultural activities and teachings, the program reacquaints Indian children (and often their parents) with the values and rituals of their culture. In addition, the Soaring Eagles staff provide positive Indian role models that demonstrate to the children how these values can be incorporated into a lifestyle that is healthy and productive. This reinforces positive self-concept and identity development in these children.

Soaring Eagles is an attempt to meld social competence, academic achievement, and positive mental health functioning into a single program for minority children. It is well known that poverty, minority status, and family dysfunctioning place many minority children at risk. Yet few programs have been designed that highlight and build on cultural values and strengths. This program addresses many of the critical components that must be in place to break the environmental conditions that so significantly impact on Indian children's lives.

Incorporation of cultural knowledge/preferred choices in practice and policymaking

The emphasis on the Indian culture and understanding Indian values and traditions is the foundation upon which Soaring Eagles is based. It is essential that Indian youth develop strong cultural identities along with other aspects of their personalities, especially in a society where they are often ostracized and isolated because of their ethnicity. The emphasis on culture also allows the program to take full advantage of the natural resources and helpers within the Indian community, thus creating a more supportive community environment for the children. Children are very important in Indian cultures, and this program seeks to reinforce that Indian value. Every aspect of the program, from its organizational structure to its staff and activities, is designed to illustrate or reflect basic Indian values. The cultural values stressed include respect for self, for other people, and for the environment. All interventions are driven by culturally preferred choices rather than by culturally blind or culturally free practices.

Each activity teaches cultural lessons and values. For example, the younger children learn the cultural value of respecting elders through various activities. This Christmas, they made a key chain and card wishing a happy holiday, and then went over to a local nursing home to give the cards and key chains to the elderly residents. The elderly people enjoyed it, and so did the children. The underlying discussion afterwards centered around respecting elders, sharing, and friendship. As one of the activity counselors noted: "The cultural part of this is very important to these kids. They have to know who they are. The Indian culture is a way of life. You can't go in there and tell them how to make sweetbread or how to burn sage and tell them it's an Indian thing. Indian culture is a way of life, you live it everyday, and you've got to show that to the kids . . . I think a lot of it is realizing that culture is not just these ritualistic things you go through; it is not just the drum and the pipe, but it is a way of life – the values, how you perceive things. We try to emphasize these things in the program and try to show the differences between what's going on in the white culture and what's going on with Indian people. We tell them that it's natural to have conflicts because often values are different. We try to do activities that focus in on the Indian values."

Even the structure and organization of the program reflect the Indian value of community. For instance, many wondered why the program was set up with an age range from 3 to 20, but the program wanted to build on the traditional value of community and the sense, in young people, that they are united and together. As an activity counselor stated, "This is a place for all of us and that, in itself, is a cultural value and that creates the sense of trust and a working environment where you can accomplish a lot."

Another basic premise of the program is that, due to the great abuse of alcohol and substances in the Indian community, many of these children and their parents are "children of alcoholics." There has been a growing acknowledgement by the mental health field that growing up with alcoholic parents has a significant impact on the development of social, psychological, and emotional components of personality. Therefore, mental health – both as a part of the milieu and as an intervention – is a critical element in the program. Although most of the children are not involved in long-term individual treatment, mental health services are available, if needed. It is a strong philosophy of the program that in order to get rid of the "baggage" associated with being "children of alcoholics," youth must have therapy services available to them.

In order to become healthy, productive individuals, the children involved in the Soaring Eagles Program receive both didactic and experiential lessons about alcohol and other drugs and the devastating impact abuse has had on American Indians as a group as well as on individual lives. Films, lectures, and role playing assist the children in understanding why they should lead alcohol-free lives as well as help them in expressing their feelings about the alcoholic lives and cultures of their families and other adults in their environment.

In addition to exposure to the more positive aspects of Indian cultural values, emphasis is also placed on educational achievement and greater knowledge of the mainstream American culture. Since it is believed that education is the major way out of poverty for American Indians, Soaring Eagles focuses on keeping children in school and having them excel. Therefore, incentives are built into the structure of the program that reinforce good grades and school achievements.

Due to the levels of poverty experienced by most of these children, their access to recreational activities and exposure to the larger Minneapolis area are very limited. In addition to all its other goals, the Soaring Eagles Program seeks to expose the children to a variety of recreational and cultural activities that are often taken for granted by mainstream children. The program takes children to museums, to restaurants, to sports events, to concerts, and to other social activities that increase their exposure to mainstream culture and teach the children how to be comfortable in cross-cultural situations.

Family as the primary system of support and intervention

The Soaring Eagles Program recognizes the culturally competent principle that "family" is the primary support and intervention point for children. For staff, family is defined as the whole Indian community, and staff view themselves as a part of the extended family for these children.

In many ways, Soaring Eagles staff members have a mixed approach to working with families. On the one hand, they welcome the opportunity to have families involved in the program; on the other hand, they see themselves as providing a period of relief for family members who are often overburdened with other issues of daily survival. The hours the children spend with the Soaring Eagles Program sometimes provide the only opportunity that a single mother may have to address her own needs.

Parents are involved in the program to varying degrees. All parents must come to the initial interview for the child's admission into the program. Some parents are also very active in the program and actually help out as group facilitators at meetings and work with specific age groups.

The highest level of parent involvement is the annual family retreat; there is a requirement that the parent accompany the child for this outing. Parents and children go away for a weekend full of activities and workshops. This retreat has proven to be very popular with the parents, mostly females, who often do not have an opportunity to stay at hotels or have a vacation. The mothers do not have to worry about cooking, and staff provide day care services for the parents while they attend workshops. Last year, over 200 persons attended the annual retreat. The cost of the retreat, for each family, is determined on a sliding fee scale based on income.

In the most recent proposal to OSAP, the Soaring Eagles staff added a component that will provide at least quarterly parent education and support meetings. These meetings will be structured so that parents receive information and have time to talk about some of the concerns they have with their children or problems they are encountering. Also, since some parents expressed an interest in learning more about their cultural backgrounds, the cultural coordinator is planning cultural education and activities for the parents as well.

Concept of responsive services

As noted earlier, all of the activities associated with the Soaring Eagles Program incorporate cultural concepts and values. The primary structure for delivering services to children are age-related peer groups. Each peer group has an activity counselor who is responsible for 25 to 35 children. The groups meet from two and a half to three hours a week. Group meetings are designed so that all groups begin together as a large group. In the opening group, all children recite the Soaring Eagles pledge and the 4H pledge and they hear any general announcements that apply to the whole group. Then, each age group goes to separate space for its evening's activity. The activities are sometimes chosen by the children themselves and sometimes by the staff. Individual Soaring Eagles members may also participate in other activities offered by the program or the social center during the week.

The cultural activities include tours on reservations; presentations by Indian spiritual leaders or tribal chairpersons; teaching children about nature, fishing, and farming; and participation in pow wows, traditional dances, sweats, and drum and bugle corps. Also, the children and staff plan activities that can occur in the city such as roller skating, eating out in restaurants, swimming, and going to concerts, plays, or movies.

As noted earlier, much emphasis is placed on academic achievement, so the Soaring Eagles Program offers many opportunities for the members to learn skills that assist them in becoming better students. A tutoring program, study period, and reading program are offered on Saturdays. In addition, each child of seven years or older must work on an individual improvement activity during the year. This improvement activity is something that the child decides on with input from the Soaring Eagles staff. For example, some of the older adolescents have worked on obtaining their drivers licenses, some take swimming lessons or a dance class, some have entered beauty pageants, some have taken karate lessons, and others have taken foreign language classes. The child can choose almost any activity as long as it is attainable, realistic, and can be accomplished within a three-year period.

The program also addresses many of the critical issues in the Indian community, providing didactic lessons to the youngsters around teenage pregnancy, AIDS, and chemical dependency. Often the approach used is creative and innovative. For example, recently a group of Soaring Eagles members went to a weekend retreat and seminar to receive training in alcoholism. They returned to Soaring Eagles as certified trainers in this area and provide workshops and peer counseling to other members.

Working with natural, informal support systems

Soaring Eagles illustrates the culturally competent principle of viewing natural systems as primary mechanisms of support for minority populations. The program has based many of its activities around exposure to natural helpers and others in the Indian community who can teach the children about their culture and assist them in positive growth and development. IHB also utilizes many cultural rituals as part of its ongoing program.

Medicine people are often involved in the healing process and children frequently participate in activities such as pow wows, sweats, and other Indian rituals/ceremonies that bring them into contact with traditional healers and helpers. In addition, natural helpers and other traditional Indian leaders often present lectures to the children or lead discussions about Indian values. Storytellers, traditional dancers, and those knowledgeable about ceremonial pipes and drums come to the program to impart these customs and traditions to the Soaring Eagles members. A local Indian artist created the Soaring Eagles logo and American Indian artists and artisans display their products at the IHB. When the IHB moved into its new location seven years ago, the executive director had one of the leading Indian spiritualists come and bless the building in a traditional ceremony. This gave sanction to the Indian community to use the building. Although the mental health program is rather traditional in approach, its staff members have learned to modify their approach and interpretations to accommodate cultural differences. For example, a therapy group may open with the ceremonial pipe or with a drum ceremony before entering into more standard group therapy sessions.

The IHB has also been quite successful in recruiting volunteers and soliciting support from various other resources within the community. In 1989, volunteers provided over 2,900 hours to the social center. The IHB has sponsored baby showers for pregnant mothers where local retailers provided baby clothes, baby products, and clothing for the mothers. Many local businesses and private citizens have provided sponsorship for Soaring Eagles youth to attend community activities or to pursue their own interest areas. In 1989, over 83 businesses and civic organizations contributed food, clothing, toys, tickets, or other materials and goods to the Soaring Eagles and other programs. These contributions have been very important in enhancing the services available to the clients.

Provision of an integrated network of services

The Soaring Eagles Program utilizes strong intra-agency as well as interagency collaboration to better meet the needs of its students. The program has formed interagency agreements with nine local agencies. There are also many informal agreements with other youth-serving organizations.

However, the most important coordination for the Soaring Eagles Program is that between the social center and the mental health unit within the IHB. The Soaring Eagles philosophy is based on the premise that the program seeks to mitigate the social isolation and school failure of Indian children; it also addresses the mental health and emotional problems associated with being children of alcoholics and living daily in dysfunctional families and communities. The assumption is that the mental health unit will provide therapeutic interventions to assure that

these children resolve conflicts before they became crippling. Although the mental health unit has provided assessments on each child in the Soaring Eagles Program, it has not offered long-term individual, group, or family therapy. The lack of collaboration and communication between the two units has become the focus of attention. Much of the problem seems to stem from the fears that each staff has of the other and a lack of understanding about what mental health is all about. The executive director hopes to address the mental health knowledge issue through a series of inservice training workshops. However, the fears and mistrusts that exist between the social center and the mental health staffs will have to be dispelled through closer communication and relationships.

Staffing patterns and ethnic composition

The Soaring Eagles Program has five full-time staff. These include the youth coordinator and four full-time activity counselors. These staff usually work 40 to 45 hours a week in the afternoons, evenings, and on some weekends. All staff are American Indian and the activity counselors are full-time college students. In addition to the full-time staff, the six staff associated with the social center also spend a percentage of their time performing activities related to the Soaring Eagles Program. Staff from the mental health clinic, all of whom are white professionals, conduct mental health assessments and provide consultation to the staff and children, as needed.

The use of American Indian college students as the primary staff for the Soaring Eagles Program has proven to be a critical factor in the success of the program. This staffing pattern seems to be unusually effective in providing realistic role models for younger Indian children and adolescents. Although the Soaring Eagles Program experimented with a number of different staffing configurations prior to utilizing college students, the latter approach has been the most effective. The executive director believes that they're young enough and, at the same time, old enough to be able to do some nurturing and that they understand a lot of the things the children are going through. The positions also have major benefits for the college students because they can work full time and go to school. In addition, the program provides a very real opportunity for them to come back and do something for their community while earning a decent wage and having full benefits. Two of the activity counselors are males and this is particularly important for young Indian boys who often do not see positive male role models in their communities.

The program staff function very much as role models and as an extended family for the youngsters. As the director of the social center stated, "One person, a long time ago, said that everyone needs to have 'cookie people' out there because parents are those that are setting limits and children, especially teenagers, don't want to hear what their parents tell them. So there need to be other guiding adults in the community to set limits, to talk to, and to give children support. That's what we try to do in this program. If we can play these roles and provide a safe place for kids to come and talk, then we have a real significance."

Understanding the dynamics of difference

The Soaring Eagles Program always confronts the dynamics of difference inherent in the attempt to instill Indian values and practices in Indian children who constantly confront a culture

of alcoholism, discrimination, denigration, and isolation. The issues related to the dynamics of difference manifest themselves in several different ways.

The most critical illustration of the dynamics of difference in this program occurs between the social center/Soaring Eagles staff and that of the mental health unit. There are some concerns about the relationship between the two units especially since there seems to be some underlying antagonism between the mental health and social center staff. A part of the issue is that the mental health treatment staff is a white, professional group while the Soaring Eagles staff consists of all American Indians, most of whom are college students and paraprofessional, whose perspectives on treatment and cultural issues may be different. Through a series of meetings and training opportunities, the director will explore the social center staff's fear and reluctance to utilize the existing mental health services and the mental health staff's attitudes and approaches to addressing the needs of the Indian children. Through this process, cultural awareness and sensitivity will be utilized to build a more effective service for the client population.

Another example of the importance of understanding the dynamics of difference occurred over the issue of establishing an Indian magnet school in the Phillips community. The IHB wholeheartedly supported such a concept. As illustrated by the high drop-out and failure rates among American Indian students, the public schools have not been effective in educating many Indian children. As staff has worked closer with the children on academic achievements, the shortcomings of the schools have become more and more clear. Therefore, several years ago staff at the IHB joined those advocating for an Indian magnet school in the Phillips community. The idea was that the Soaring Eagles Program would be relocated into the school and become better integrated with the educational process.

One of the major arguments against the Indian magnet school concept is that such a school would further isolate Indian children and deter them from successfully assimilating with the rest of the population. Many of the Indian children argue that although the existing schools are, supposedly, integrated, they find that racial/ethnic groups tend to stick together with little interaction between them. Thus, although there are children from various ethnic backgrounds in the schools, there is very little intermingling and a substantial amount of hostility. Soaring Eagles Program staff acknowledge that Indian children would be isolated in magnet schools, however they argue that the children will receive a good sense of identity, a good sense of who they are culturally, and a good sense of well-being. Once they have these basic backdrops, they can go out and explore the broader community and feel very comfortable about doing that. If they're confronted with racism, rather than coming back and hiding in the community, they will be better able to stand up and challenge it directly. These are the benefits they would receive from a school that incorporates Indian values and culture (including an expanded Soaring Eagles Program) and which provides a positive environment in which academic achievement can occur. It is believed that these benefits outnumber the problems inherent in establishing a separate school. With a magnet school structured like this, staff from the Soaring Eagles Program could also provide consultation and training to other schools where there are smaller numbers of Indian children. During the site visit, the school board of Minneapolis voted in favor of establishing the proposed Indian magnet school in the Phillips community.

Cross-cultural differences also arise in the use of volunteers in the Soaring Eagles Program. Many of these volunteers are white college students. Staff believe that it is important for Indian children to have positive experiences with non-Indians. They also believe that it is important for children to observe the interactions between the Indian staff and white volunteers. Volunteers for the program must complete an application form and be interviewed by the staff. In the interviews, the staff attempt to assess the volunteers' response to Indian children and their attitudes towards Indians in general. This response is the primary criteria used to determine whether the volunteer can work with the children in an appropriate manner.

The issues of cross-cultural differences often arise when funding is involved. Oftentimes, funding source requirements may work at cross purposes with some of the goals or directions needed for programs; hence, it is extremely important to minimize the influence any one funding source may have over the direction of the program. The goal of each IHB program is to ensure that no more than 40 percent of its funding come from any one source. In that way, if the program were to lose funding from one source, it would not mean the complete closure of the service. Rather, staff could seek another funding source or could cut back on certain components of the program. It is very important for programs serving minority children or poor communities to be consistent and continuous. Oftentimes, programs are started and, in a few short years, they disappear. The executive director does not believe this is helpful to the community and has sought to develop programs that have a diversity of funding and the capacity to endure fiscal hardships.

Minority participation at all organizational levels

Since the IHB is a minority-owned organization, there is Indian representation at every level of the agency. The IHB operates with a board of directors that consists of nine persons elected by members of the corporation. Eight of the nine members of the board are Indian. Board members include a traditional singer, a lawyer, and a grandparent. The key to the effectiveness of this board of directors is that its members have a strong commitment to the notion that Indian people deserve first class services and programs.

Support of self-determination for the broader minority community

The concept of self-determination is one of utmost importance to Indian people and tribes throughout this country. The IHB has, over its 20-year existence, built a strong advocacy base and community support network. In many ways it has become a fixture for many Indians; even though the community changes, the IHB maintains a sense of unity and continuity. It is a central meeting ground for Indians – they come to the board for social services, health services, and mental health services. Within the IHB, there has also been consistency and continuity. The present executive director has been in that position for more than 16 years. Thus, a sense of history, purpose, and community service are associated with the very mention of this agency. Due to strong leadership, the agency and its staff have become very influential in addressing policies affecting the American Indian community.

One of the most convincing illustrations of IHB's strength is the recent decision by the Minneapolis Board of Education to work with the IHB in establishing an Indian magnet school at the elementary and junior high school levels. The IHB was able to muster support from the students, their parents, other Indian organizations, local legislators, and influential state legislators. Although this shows the strength of the organizational effort, the magnet school issue was also used by the Soaring Eagles Program to teach the children and their parents about participating in community activities that have major impact on their lives. This year over 100 Soaring Eagles, ages 3 to 20, attended the series of meetings held by the Minneapolis Board of Education to address the Indian magnet school issue. Not only did the children and many of their parents sit through hours of testimony for and against the proposed school, but some of the Soaring Eagles children even testified themselves – as did some of their parents. These types of experiences reconnect the children and their families with the community and allow them to see that they have a voice that can be heard.

The Soaring Eagles program also seeks to promote self-determination among its students by teaching them to understand and be cognizant of issues in the larger society. For example, at the same time that children deal with the effects of alcoholism on an individual basis, they are helped to understand the form of genocide that has been promulgated on American Indians, as a group, with the introduction of alcohol. The program seeks to establish more positive and stronger Indian identities as a coping mechanism to counteract the racism and discrimination the children experience from the larger society.

ADA S. MCKINLEY COMMUNITY SERVICES
ADA S. MCKINLEY INTERVENTION SERVICES
Chicago, Illinois

At the Ada S. McKinley Intervention Services Program, cultural competence training is a crucial requirement in staff training. The training curriculum incorporates the principles of home-based treatment interventions for minority populations and promotes certain culturally based strategies of engagement for these populations.

Brief History and Identification of Agency

Ada S. McKinley Community Services (McKinley) is a non-profit social services organization founded by an African American social worker, Ada S. McKinley, who started the agency over 60 years ago as the South Side Settlement House, one of the first community houses in Chicago. The settlement house provided a broad spectrum of social services for the African American community residing on the South Side of Chicago. In 1949, it was reorganized and renamed after Mrs. McKinley in tribute of her 30 years of leadership and self-sacrifice. Over the years, the agency has grown from being a small settlement house into an organization offering 32 different programs in 20 different locations throughout the South Side. The program focus of this report is the McKinley Intervention Services.

The Intervention Services began in 1982 with a contract from the state of Illinois to provide services to 10 children with serious emotional disturbances (SED) returning to the community from out-of-state residential placements. Since that period, the Intervention Services have grown and expanded while continuing to be a community-based, family treatment effort designed to provide home-based family treatment and comprehensive concrete services at the community level for multiproblem families and their emotionally disturbed children. Currently, the Intervention Services consist of four program components: the Mentally Ill (MI) component; the Developmental Disabilities (DD) component; the Screening, Assessment and Support Services (SASS) component; and the Unified Delinquent Intervention Services (UDIS) component.

Community Description

The Intervention Services components are focused on clients who live on the South Side of Chicago. The South Side is a very heterogeneous community, consisting of African Americans, a growing number of Latinos/Hispanics, and a variety of white ethnic immigrants. The socioeconomic status ranges from those below the poverty level to middle-class families. A large proportion of the minority population reside in housing projects or other low-income housing areas. The South Side geographic area covers approximately one-third of the city. The area runs east to the Woodlawn suburb, west to Cicero, and south to 103rd Street. The South Side has an unacceptably high rate of illiteracy, infant mortality, and children born with handicapping

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conditions. The public school drop-out rate, truancy rates, incidence of teenage pregnancies, juvenile crime, and substance abuse rates are among the highest in the city of Chicago.

Target Population

The target population for the Intervention Services are children within the geographical area of the South Side who experience developmental disabilities or serious emotional disturbances. For the developmental disabilities services, children can range in age from zero to 22. For the mental health services, children are between the ages of 5 and 18. Recently, the Intervention Services expanded to address the juvenile offender population. This group consists mostly of adolescents between the ages of 10 and 18.

Although the services are open to all on the South Side, the actual clients of the Intervention Services are determined by the funding sources for the various program components. Most of the clients are African American (80 percent), 15 percent are white, and 5 percent are Latino/Hispanic. Almost all the families are poor and many are single-parent, female-headed households. There is an increasing number of grandmother-headed households in the area. There are also extended families and a small proportion of intact families.

The profile of the typical child/adolescent involved with the Intervention Services is one that: is of ethnic/racial minority status, has poor peer relationships, has experienced multiple separations and/or losses, has a poor sense of "self" and of autonomy, has low self-esteem, exhibits combative behavior and/or oppositional behavior, is self- and other-abusive, dislikes and is resistant to authority figures, and has periods of simple and/or major depression. In all of the Intervention Services components, the youth are at risk of out-of-home or institutional placements.

Program Philosophy and Goals

The theoretical orientation of the Intervention Services program components is that, in order to effectively serve families with emotionally disturbed youth, treatment alternatives that take the mental health professional out of the office and into the community must be used. The Intervention Services have adopted a family systems approach, within an ecological framework, which provides families with the necessary therapeutic interventions and concrete services that address emotional and basic needs.

The major goal of the Intervention Services is to break the cycle of dysfunctional behavior within multiproblem families. This entails reducing risk factors that ultimately result in the child/adolescent being excluded from home, school, or the community. This goal is obtained through attempting to:

- Sustain the child/adolescent in his/her own home
- Reduce risk factors of abuse and/or neglect

- Circumvent psychiatric hospitalizations
- Provide ongoing screening and assessments
- Help family members learn healthy patterns of communication
- Assist the family in identifying and utilizing needed community resources
- Teach the family how to negotiate and collaborate with the various systems impacting on their lives

SERVICES

Although the Intervention Services operates four separate components, the services offered to clients are similar and vary only in frequency and level of intensity. These service components, available to all Intervention Services clients, include: home-based family therapy, individual treatment, adolescent group counseling, parent support/educational group training, psychiatric/psychological evaluations, substance abuse assessments/counseling, intensive outreach, therapeutic companion services, network and linkage services, advocacy services, 24-hour crisis intervention – seven days a week, in-home and out-of-home respite care, ongoing screening and assessment, and aftercare and follow-up services.

In addition, programs within other divisions of McKinley are also available to these youngsters and families. The services most utilized are the day treatment programs within the Educational/Therapeutic Services and the programs within the Educational Services Division. McKinley also operates a food bank and provides clothing and other concrete services to families when needed.

FUNDING

McKinley has an annual budget of over $16 million. The agency is 95 percent dependent on state and local government contracts. The major funders are the Chicago Board of Education, the Illinois Department of Mental Health/Mental Retardation, the Illinois Department of Children and Family Services, and the Illinois Department of Public Aid (residential services). The agency also has several federal grants including Talent Search and Upward Bound, both focused on educating disadvantaged students. A small amount of private funding comes from the United Way. The agency does no third party billing for services. All services rendered are free to the client.

The Intervention Services had a budget of $1.3 million in FY'90. It was totally dependent on government contracts for all its programs, with 98 percent of the funding coming from the Department of Mental Health/Mental Retardation.

Program Efficacy

Since the Intervention Services program components are so dependent on government contracts, there are built-in mechanisms to assist evaluation. Although these do not provide an overall, in-house evaluation, submission of reports and statistics do allow the various program components to monitor their progress. There does appear to be high consumer satisfaction with the program as evidenced by the information collected in three-month follow-ups. This information is gathered through formal and informal contacts with the families by Intervention Services intake workers. However, Intervention Services is currently developing a consumer satisfaction survey that can be completed by clients when they terminate.

Since many of the program components have specific outcomes, such as reduction in psychiatric hospitalizations or reduced recidivism in the juvenile justice system, these outcomes provide measures by which the effectiveness of the services can be reviewed. To date, outcome measures have been positive for most of the families receiving services from the Intervention Services. Over the years, the program has served more than 400 youngsters and their families. Out of this number, only six youth have been recommended for residential placement by the Intervention Services staff.

In the Mentally Ill component, there has been a reduction in the hospital recidivism rate for clients in the program. In the last eight months, only one client has returned to the hospital. In the Unified Delinquent Intervention Services program, the staff is experiencing a 50 percent success rate. However, there are many problems with the attitudes of the courts and the treatment length restrictions that affect the success of the interventions for these youth. The Developmental Disabilities program component has been able to maintain most of its clients in the home setting. Only one has been placed in a residential program over the last several years. Staff believe that the focus on in-home therapy, the intensity of services, and the workers' sensitivity to the cultures and values of the client population are major factors in these outcomes.

Cultural Competence Principles

Acknowledgement of unique issues of bicultural/bilingual status

One of the basic principles of the Intervention Services is that African American families must be approached with a recognition of their bicultural status. From the very onset, there is an attempt to design an intervention that fits with the types of families and communities that are being served – which are primarily African American and low income. Almost all of the literature on mental health treatment has noted the underutilization of mental health services by this population as well as the stigma often associated with mental health. The no-show rates at mental health centers are very high. Often, minorities tend to be found in the most restrictive settings, such as hospitals, juvenile justice facilities, and residential programs rather than in facilities based in the community. The Intervention Services have focused on those African American children and adolescents who are in these more restrictive settings and have offered an alternative that has been effective in returning the youngsters from more restrictive settings

to the community, in maintaining them in a treatment process for long periods of time, in maintaining them in community placements, and in involving families and other community resources in the process.

With multiproblem families, mental health services address only one aspect of the problem. For this reason, understanding the complexity of the problems requires a comprehensive treatment approach. While many of the at-risk families may have had prior involvement with mental health services, the traditional treatment approach has often effected little change. Children are being repeatedly removed from their homes, resulting in longer and longer separations from their families. Once a child is removed from the home and family, the family has a tendency to reorganize itself around the missing family member, making it difficult for the child to be re-integrated into the family system.

Recognizing the at-risk nature of the population, based on socioeconomic status and ethnicity, the Intervention Services have designed a system that increases the accessibility and acceptability of mental health services. The most unique aspect of the Intervention Services program is that all therapy services are home-based; staff is committed to this treatment approach. Given the difficulties and resistances to mental health services offered to poor, minority populations, this approach immediately minimizes the conditions that give rise to these findings. From the intake interview through treatment termination, services are offered to clients in their own environment. This allows for maximum participation of all critical family members, including grandmothers who are very important in the African American family structure and other siblings who may not yet be symptomatic.

When families must come to the Intervention Services office site, the staff attempt to create a family atmosphere. The office is in an accessible location and many of the families served live nearby and are encouraged to "drop in." There is a simulated family living room on the ground floor with pictures and paintings of ethnic group members decorating the walls. Staff share offices that are also decorated with ethnic paintings and posters. The atmosphere is friendly, supportive, and warm.

Incorporation of cultural knowledge/preferred choices in practice and policymaking

With the home-based approach utilized by the Intervention Services, there is an acceptance of the notion that a person's reality is shaped by his culture and contextual environment. The Intervention Services view the family as the key to the success of maintaining the child/adolescent who is seriously emotionally disburbed in the home. This approach takes the focus off the individual client to that of looking at the total system as an interlocking force. Furthermore, providing services in the family's environment gives the workers access to examining problems that would not be exhibited in a traditional office setting. Treatment, therefore, addresses the overall psychological makeup of the individual as well as any impact from internal and external stressors.

In order to accomplish this, the Intervention Services staff integrate the following principles into their service delivery approach:

- The family is the identified client.
- When families are viewed from a growth perspective it increases their chances for success.
- Services are client specific and are tailored to fit the individual client.
- All families are assessed for their cultural uniqueness.
- The family's natural environment provides clues concerning the family's sense of equilibrium.

Family as the primary system of support and intervention

For the Intervention Services staff, "family" is defined as those who live within the home and/or have significant influence on the relationships within the home setting. For many of the African American families receiving services, family may include grandparents, relatives, siblings, friends, neighbors, boyfriends, and others. Each family is defined by the client.

Regardless of how the family system is defined and structured, one of the major goals of the Intervention Services is to empower families to negotiate the bureaucratic systems that impinge upon them and to find constructive methods for solving problems that arise. With the emphasis on therapy in the family's home, the worker steps onto the family's turf, thereby immediately empowering the family. The issues of control are instantly diffused. All of the families are interviewed in their homes at intake. Determination is made as to which family members will be involved in the treatment process, and initial and ongoing goals of the treatment plan are set. Family therapy is provided in home once a week with the family therapist and community worker. According to the parents interviewed, this is the most outstanding highlight of the McKinley program – that the staff come to them; that they help them deal with daily crises and situations; that they are available day and night, if needed; that they do things with their children (both identified clients as well as siblings); and that they are warm, supportive, and help clients handle their feelings and problems better. As one parent stated, "What we get is worth a lot of gold, and we get it free."

Home-based services have empowered families who often see themselves as helpless, hopeless victims in the larger society. Rather, these families, with the assistance of the Intervention Services team, have been able to conceptualize problems in such a way that solutions become possible rather than having a problem be overwhelming. Since the treatment process provides both concrete and mental health services, Intervention Services workers have been able to help families set goals and objectives that provide a method for measuring success. The treatment goals are those set by the family rather than by an outside agency or professional. When these goals are met, the family feels a sense of achievement and, hence, empowerment.

In addition to the in-home therapy, parents are also encouraged to become involved in a number of other activities offered by McKinley. The Intervention Services have parent groups on Wednesday nights for parents involved in any of their program components. These groups include both parent education around specific topics as well as parent support. Transportation is made available to the parents, or they can receive car fare. Food is always served at these group meetings.

The director has also established a Parent Advisory Committee consisting of four parents. This group meets on a monthly basis with the director to provide input about program services or about ways the agency can more effectively address the needs of parents. There are two black and two Latino/Hispanic parents on the current committee. All of the parents except one have been or are currently receiving support from the Intervention Services.

The Intervention Services also sponsor a number of special activities that involve parents or families. For example, the Intervention Services periodically hold "the dusty nights" – a night when parents are invited to come to the center and listen to old records from the '50s and '60s. There is food and parents can dance or just socialize with other parents and staff. There are also major activities during the summer where families and children are involved. These include trips to the amusement park, a family barbecue and picnic, and a McKinley "ball" for parents. Sometimes community workers also take the whole family on some of the therapeutic companion activities such as visiting the zoo or going bicycle riding. The agency recognizes that these parents often have few opportunities to relax and have activities that are nurturing to them. Therefore, these activities tend to be well attended by families.

Importance of cultural assessments

Family assessments are considered critical to the Intervention Services treatment process. These assessments address a number of cultural factors that assist in determining the types of interventions and strategies to be used in working with the family. These cultural factors include: a knowledge of the "generational" issues (i.e., determining whether this is a first- or second-generation Chicago family, since migration from the south or another part of the country often has some impact on mental health status); information about the level of religiosity of the family and its members; and child-rearing patterns and beliefs. In addition, the worker also assesses the basic needs of the family as well as the level of skill development in family members. Finally, an assessment is also made of community resources that might be available to the family in addressing some of the agreed-upon problems.

Concept of responsive services

The home-based approach allows services to be delivered in a manner that is flexible, dynamic, and responsive to the changing needs of the family. Services are delivered in a way that shows families the utmost respect and dignity. Due to these factors, families regard the Intervention Services as very unique and responsive to their needs. During the site visit, a staff member noted that: "No one offers all the home-based services and outreach that McKinley does. We make the family feel good in its own environment; and it's not just one person, but a family

thing. We also monitor their child's progress in school, have a 24-hour on-call service, and provide a lot of recreational activities for the children. We can go out and get the client or provide transportation. We're a very flexible agency."

If resources needed for a family are not readily available, Intervention Services staff seek to develop that resource. One service that is currently being developed, based on assessments of resources needed by clients, is a respite component. Intervention Services program staff do not use any resources that are not easily accessible or readily available to their clients. For example, they do not make referrals to services that are on the other side of town, since they know from experience that families often do not or cannot get to these services.

Working with natural, informal support systems

It is one of the goals of treatment to connect families with the available resources within their communities. Therefore, community workers spend a considerable amount of time learning about these resources. A particular emphasis has been placed on networking with ministers. The Intervention Services would like the churches to be resources when issues of safety arise in certain neighborhoods, especially in those areas with housing projects. For example, churches often provide space for family meetings or during other times when the projects are considered unsafe. Similarly, recreational resources in the communities are often tapped. The activity counselor is especially important in networking with these types of resources.

It is one of the policies of McKinley that networking with other services in a particular area is critical. This has also been the reason why McKinley locates programs in many different sections of the South Side rather than in just one or two areas. As soon as a McKinley program is established, the staff is expected to do outreach to the community in which it is located. This allows staff to find out about resources available in the community as well as to offer their building and staff for community activities. The motto is that McKinley is "here to serve, not to harm the neighborhood." Therefore, McKinley sites are often used for community meetings by various organizations. The staff view other resources as important and "cultivate them as friends."

Provision of an integrated network of services

Interagency coordination is critical to the functioning of many of the components of the Intervention Services program. For example, the Screening, Assessment and Support Services (SASS) component does not work unless there is coordination between mental health, state and private hospitals, and McKinley. Such coordination involves monthly meetings and ongoing communication when problems arise. The same is true for the Unified Delinquent Intervention Services (UDIS) program, although the involved agencies differ. The effectiveness of the services and their ability to impact on these multiproblem families is dependent upon interagency coordination.

In order to impact on interagency coordination, McKinley staff participate in monthly meetings with service providers in the Chicago area, they participate on state/local task forces, and they attend and sponsor community seminars and workshops. Over the years, since so many

of the McKinley programs also address educational needs of children, the agency has developed excellent relationships with many of the school principals, teachers, and counselors in South Side schools.

McKinley, itself, provides a large range of social and educational services that are available to clients in the Intervention Services. These include the following services:

Adult Rehabilitation Services – This division operates three sheltered workshops for developmentally disabled clients. Through training, employment, and supportive services, these clients are afforded opportunities to achieve their optimum level of independent, social, and economic functioning. Program services include: developmental training; work-adjustment training; assistance in obtaining and retaining competitive employment, and supported employment; and basic educational services.

Educational/Therapeutic Services – Services in this division are designed for the minority child and his family in cases of emotional disturbance and mental retardation. The division operates five schools for children of school age who have special needs; it also operates early intervention and preschool programs as well as a program for severely handicapped adults. The early childhood intervention program, Alpha, provides home-based and center-based services for infants younger than three years of age who are known to have delays or whose medical screenings indicate a need for further evaluation. The program offers individual assessments, physical therapy, occupational therapy, family nutrition training, speech and language services, psychological services, and family counseling. The division's second major service component is its South Chicago Family Support Program. Here, services ranging from Head Start and preschool for children, to recreational and educational services for youth, to nutritional and social services for seniors are provided.

Educational Services – The primary objective of this division is to assist Chicago's inner-city high school students in pursuing successful careers in higher education. Education for these large numbers of young men and women, virtually all from poverty-level families, is the open door to financial security and personal fulfillment. During a typical year, the division places approximately 1,500 students on the campuses of American colleges and universities coast to coast. The staff also participates in "college fairs" and meets with scores of high school groups each year. A major project is the division's Adopt-a-School program, which pairs seven colleges and universities with seven Chicago inner-city high schools to provide resources that strengthen the college preparatory curriculum.

Foster Care Services – McKinley provides a community-based foster care program utilizing specially trained foster families to care for children with problems. The primary focus is to utilize the trained foster parent to reunite the child with the natural family and, where this is not possible, to provide the child with a stable environment in the foster family setting. The division currently provides traditional and specialized foster care, as well as adoption services.

Residential Services – McKinley currently operates five, 15-bed Intermediate Care Facilities for mentally retarded adults between the ages of 26 and 35. The division also plans to participate in a new initiative and concept in residential services called Community Integrated Living Arrangements (CILA). The goal of this effort is to keep retarded citizens and/or mentally ill clients within the community and provide all of the services necessary so the individual can remain within the community and out of an institution. To meet the residential needs of this population, the CILA concept allows and encourages the development of residential facilities of up to eight-bed units. The division hopes to develop 100 CILA beds over the next five years.

Given the range of these programs, it is very important that there be coordination and ongoing communication between the Intervention Services and other McKinley divisions. This is assured through monthly meetings as well as through a policy that provides easy access to families involved in any one McKinley program to services offered in other McKinley programs. Clients are able to move throughout the McKinley service system and receive what they need in a very non-disruptive manner.

Staffing patterns and ethnic composition

At the time of the site visit, the Intervention Services employed 34 staff. Of this staff, two were administrative positions and five were support staff positions. The remainder were treatment staff – either family workers, community workers, and/or unit coordinators. There was also one activities coordinator who worked with the community workers around the development of therapeutic recreational activities for clients. Eighty-two percent of the staff were African American, 15 percent were white, and one staff member was Latino/Hispanic. All of the family workers were masters-level professionals with degrees in social work, counseling, education, or psychology. All of the community workers must have graduated from a four-year college. The ethnic makeup of the staff reflects the largely African American clientele of the Intervention Services. The agency is committed to matching the ethnic/racial makeup of its staff with that of the South Side community it serves.

In addition to the full-time staff, the Intervention Services program also provides placements for social work students and interns from the local universities. There are usually no more than two students in the program at any given time due to the extensive supervision necessary.

A clinical consulting team provides specialized services to all components of Intervention Services. With one exception, all of the members of this consulting team are white professionals. The team includes a psychiatrist who provides psychiatric evaluations and medication therapy/monitoring, a clinical psychologist who provides psychological testing and behavioral management plans, and a Ph.D. clinical social worker who provides case consultation and reviews clinical/supervisory issues. In addition, a Latino/Hispanic substance abuse specialist has been added to the clinical consulting team to provide in-home evaluations and limited counseling around alcohol and drug abuse use in families, since this has been identified as a common problem.

All of the services delivered by Intervention Services utilize a team approach. This ensures that there is always someone available to the family. Usually a team consists of a family worker and one or more community workers. There are attempts to ensure that there is a male and female on each team, although this is not always possible. The family worker and community worker are co-leaders in the in-home family therapy sessions. In addition, the community worker provides individual counseling and therapeutic companion services for the identified child (and, often, siblings).

There is considerable emphasis on the screening and selection of staff to work with these families. Cultural issues are considered extremely important. Training, case consultation, and treatment interventions tend to emphasize cultural issues rather than ignore or bypass them. There is an intensive staff orientation and ongoing in-service training around the impact and importance of cultural values and issues in the therapeutic process. Cultural values are discussed and observed in the family assessment and treatment planning processes. Staff are encouraged to explore their own values and feelings about racial issues and cross-cultural situations.

Cultural competence training

Staff training is a crucial component of the Intervention Services programs. All new Intervention Services employees undergo a two-week training orientation prior to developing their own caseload. The director finds that this orientation is critical as the worker must address cultural issues as well as a nontraditional intervention model – home-based therapy. She has constructed a training curriculum that incorporates the principles of home-based treatment interventions for minority populations and assists new workers in working through the engagement process as it relates to minority clients. The curriculum, entitled *Clinical Work with African American Families*, has five teaching units. The introductory unit on confronting racism sets the stage for the training on cultural competence as it relates to clinical work with African American families. Other units include value clarification, learning patterns of individuals, Maslow's hierarchy of needs and the implications for multiproblem families, and the psychosocial interviewing process.

Besides lectures and didactic readings, the Intervention Services program also uses other approaches to training its staff. For example, the orientation includes a documentary film, *Crisis on Federal Street*, that explores life in a Chicago housing project. The film is used to open up discussion about such things as what it means to go into a housing project and what it means to work with a multigenerational public assistance family. After discussion, the worker is asked to develop a treatment plan for the types of families featured in the film. There is also opportunity for staff to role play and demonstrate how they would address racial issues that might arise with families. Also, as a part of the orientation new staff accompany teams on home visits and observe the team's direct involvement with McKinley families.

Ongoing staff training also occurs weekly for two-and-a-half hours each Monday. This ongoing training consists of lectures, case consultations, or presentations from guest speakers about a topic relevant to the work of the Intervention Services teams. There is an emphasis on many aspects of the role of culture in clinical practice.

Understanding the dynamics of difference

The Intervention Services staff often have to address and be concerned with understanding the dynamics of difference, since a percentage of the staff and clients are not African Americans. In working with families, the Intervention Services teams are cognizant of racial issues and composition. There are some occasions when an African American worker may work with a white family and vice versa. However, in all cross-racial situations, the issue is brought up and addressed early in the family sessions. Although race as an issue is usually denied by the clients, the worker gives the family the option of bringing it up in later sessions, which often happens. If a family has strong feelings about working with Intervention Services team members that are not of the same race, this may sometimes mean that the family seeks services elsewhere or remains on the waiting list until it can be matched by ethnicity.

Minority participation at all organizational levels

There is minority participation at every level of the Intervention Services. The director and division director are African American, as are all the coordinators of the program components. Thus, minorities are integrated at all levels of the administrative and programmatic structure of the Intervention Services.

McKinley operates with a highly active and energetic board of directors. There are 26 board members; 13 are African American and 2 are Latino/Hispanic. The primary function of the board is to establish policies for the agency. It also has a fundraising function and has been successful in raising $500 thousand annually, primarily to meet costs associated with maintaining the McKinley properties. The board holds titles to the properties and controls all other fiscal aspects of the agency's operation.

Support of self-determination for the broader minority community

McKinley's board and executive management staff have been highly political. They have sponsored events, both in the Chicago area and in the state capital, that bring their services and programs to the attention of state legislators and city aldermen. Several state legislators and city officials are members of the McKinley board. These contacts have tended to be very helpful to the agency and its clients.

As noted earlier, one of the major goals of the Intervention Services is the empowerment of families. This includes power not only within the family system but in the larger community in which families interact. A part of the treatment process includes teaching families how to deal effectively with bureaucratic systems and resistance. Teaching the family about how to negotiate and collaborate with the various systems gives a sense of empowerment resulting in the development and maintenance of a healthier environment for family and community interaction.

PROGRESSIVE LIFE CENTER, INC.
Washington, D.C.

At the Progressive Life Center, African American clients are seen as evolving from positive African cultures which have been negatively impacted by slavery and racism. The center recognizes and respects the bicultural nature of the African American experience and views this experience as a key element in service delivery.

Brief History and Identification of Agency

The Progressive Life Center, Inc. (PLC) is a private, non-profit human services firm that provides psychological services to individuals, couples, and families. PLC also provides management training and organizational development services to public, private, and government-sector organizations. Begun in 1983, the PLC started with a small demonstration grant from the District of Columbia government to provide community services to habitual and repeat juvenile offenders returning to the community from juvenile detention facilities. The PLC is a minority-owned agency serving minority clients.

The founders of PLC also formed a for-profit corporation, the Progressive Life Institute (PLI), in 1983. PLI is a mental health outpatient clinic that operates on a fee-for-service basis. All clients served through this corporation are private citizens with third party insurance or ability to self-pay.

In 1985, PLC spun off a third organization called Progressive Life Enterprises (PLE). Using the African concept of "cooperative economics" as a framework, the PLE controls all the capital assets of the Progressive Life Center. These currently include three office buildings that house the PLC staff and programs. Based on an equity sharing system, 51 percent of the shares are held by the executive director and board of the PLC. The remaining shares are available for purchase by PLC staff.

Community Description

The PLC operates within the environs of the nation's capital. In many ways, Washington, D.C. is a "tale of two cities" -- one affluent, wealthy, and powerful; the other poor, disadvantaged, and disenfranchised. The District has the highest per capita income for individuals in the United States, yet its poverty rate for African Americans is among the highest in the country. Within the 67 miles that compose the nation's capital, there is a population of 628,600 persons. Almost 75 percent of the population is African American, 17 percent is white, and the remainder is a combination of Latinos/Hispanics, Asians, and other immigrant groups.

The African American community in the District is extremely diverse. It has the highest number of African American professionals per capita in the United States. Yet, the city has a

disproportionately high number of children in foster care placements, juvenile detention, and out-of-state residential treatment facilities. The District also leads the nation in black-on-black homicide deaths, which is the leading cause of death for African American adolescents between the ages of 12 and 20. The impact of drug abuse in the African American community has also been devastating.

Target Population

The PLC views the African American community in Washington, and its organizational structures, as its primary clients. However, due to the reliance on government contracts, the specific clients are determined by the funding agency. For the most part, PLC clients are African American youth and their families who are involved in the juvenile justice, child welfare, or mental health systems. These children may be in institutions or in the community. The average age of the clients is 13 to 15 years.

Another population for which PLC has gained treatment expertise is African Americans who are HIV-positive or who have full-blown AIDS. Through contracts, the PLC offers services to this target population and their families as well. These services are available to pediatric cases, adolescents, and adults.

In both of these target populations, the majority of clients are males, although there are a growing number of females. The family members involved in the treatment process are overwhelmingly female, since almost 90 percent of the clients reside in female-headed households. Although a DSM-III diagnosis is not required for many of these services, most of the youth in the PLC target population would receive a diagnosis of conduct and oppositional disorders. PLC also finds a large proportion of character disorders on Axis II of the DSM-III.

Program Philosophy and Goals

The PLC was founded on the concept of integrating and merging African psychology and African American cultural practices with humanistic and interactional models of psychotherapy. Through this unique combination, called Afrocentric psychology, the founders of PLC hoped to create a model that would be more effective in intervening in the lives of African Americans experiencing stress and other symptoms of dysfunctional behavior due to societal racism as well as internal conflicts.

The PLC operates from an Afrocentric (culturally based) framework specifically identified as "NTU" (pronounced "in-too"). "NTU" is a Bantu (central African) concept which loosely translates as "essence" of life and signifies a universal, unifying force which touches upon all aspects of existence. NTU highlights the interrelatedness between the intrinsic (psychic and immaterial) and extrinsic (social and material) factors which impact upon a person's ability to both influence and respond to problems of daily living. These principles emphasize the positive strengths of the individual and their culture, rather than approaching the treatment process from a deficit model, which many psychological theories do.

When these Afrocentric concepts are applied to a therapeutic process, then the major goal is to "heal" the dysfunctioning so that the individual, group, family, or organization can return to a more balanced and positive manner of living, in greater harmony with themselves and their larger community. This healing occurs through the context of the relationship with the therapist and an increasing acceptance of the NTU principles. PLC believes that there are phases of treatment based on the NTU healing process. These phases are harmony, awareness, alignment, actualization, and synthesis. These phases are seen throughout the therapeutic process and all problems can be addressed and solved within the context of the stated principles.

The PLC Afrocentric philosophy also assumes that a major goal is to incorporate cultural values and concepts into every aspect of the agency – from the way the agency is structured, to the way that services are designed and delivered, to the way in which staff relate and respond to each other. All of these factors must be in harmony and unity if efficient services are to be offered to clients.

Services

The PLC provides a full array of services to clients. These include: individual and family assessments; individual, group and family psychotherapy; in-home family counseling; multiple family retreats; AIDS counseling and education; psychological testing; forensic psychology; crisis intervention; parent education and training; Adolescent Rites of Passage; hypnotherapy; and management consultation, training, and team building.

Funding

In the last fiscal year, the PLC had revenues totalling over $1.2 million and expenses totalling $1.1 million. These revenues came primarily from contracts with District of Columbia government agencies. The agency also has some funding through federal grants. In addition, at the time of the site visit the PLC had also received a contract from Prince George's County, Maryland to train staff and provide services to youth-at-risk for the County Commission on Families.

Program Efficacy

The PLC has not developed an extensive evaluation of its program components, although various data elements and statistics are in place. Service delivery statistics and demographic information are available on most programs since they are funded through government contracts.

All PLC training modules and workshops are evaluated for content and process by participants immediately after the conclusion of the training. PLC has received extremely positive responses from participants. However, the long-term impact of the workshops on professional competency or on improved service delivery cannot be measured through these evaluations.

Although feedback on program efficacy and client satisfaction is very positive, the PLC is moving towards a more formalized monitoring and evaluation process focused on the outcome and effectiveness of services. PLC has hired a Director of Evaluation and Research to develop

these mechanisms. The PLC staff believe that it is critical to have more solid and empirical evidence to validate their treatment philosophy and service delivery approach.

Cultural Competence Principles

Acknowledgement of unique issues of bicultural/bilingual status

The PLC was established specifically to address the unique issues associated with being African American in an American society that is filled with racism and denigration of African American culture. Mental health theories have contributed to a view of African American persons and institutions as "pathological" and "deficient." However, these theories do not address the detrimental impact of slavery and pervasive racism on the psychological development of African Americans. These theories also do little to develop positive self-esteem or identities for African American children and families.

The PLC has developed a psychological model that provides and reinforces the notion that there is a positive African American "culture" and that the values associated with this culture can offer a more effective way for understanding dysfunctioning among the African American population. The cultural framework utilized by PLC is built upon NTU and the principles of Nguzo Saba, described below.

Since many mainstream mental health agencies do not recognize or respect the biculturality of African Americans, it is often stated that African Americans are resistant or inappropriate for mental health interventions and treatments. There is no recognition that often these clients are "system-abused," i.e., they have had contact with so many agencies and been treated in such demeaning manners that they are often hostile and wary of offered interventions. In addition to offering a cultural framework for mental health interventions, the PLC also incorporates other values that increase the accessibility and acceptability of mental health services to African American clients.

First of all, many PLC services are offered to families within their own homes. When clients come into the center, PLC has located its offices so that they are community-based and accessible by public transportation. Selections of sites are undertaken with great care and consideration by the staff at PLC. It is very important that the site provide a warm, home-like environment so that the stigma of mental health services is lessened. The African American community has a somewhat cautious, and often negative, association with mental health services and PLC works hard to overcome this stigma. In each site, a casual onlooker would never know that mental health services were being offered. Even the name of the center was selected to give a positive connotation. The waiting rooms and offices are filled with magazines and other reading materials focused on African Americans. There are posters, paintings, and African sculptures and artifacts throughout.

Incorporation of cultural knowledge/preferred choices in practice and policymaking

The PLC philosophy and intervention techniques are based on a strong theoretical orientation which suggests that African cultural values and principles continue to be exhibited by African Americans today, and that these values and principles can be utilized to resolve some of the psychological and social conflicts that are presented by African American individuals and communities. This coherent philosophy, which permeates every aspect of the PLC's operation, provides a solid foundation from which to deliver services to the African American community. The PLC acknowledges and accepts that culture and cultural values are a predominant force in shaping behaviors, values, and institutions. As noted earlier, these are based on NTU philosophy and Nguzo Saba principles.

The NTU philosophy, as developed by the PLC, sets forth that optimal functioning is facilitated by a psychosocial environment in which the individual experiences and practices the principles of harmony, interconnectedness, authenticity, and balance. These principles are briefly defined as follows:

Harmony – There is a vibrant belief in a spiritual force that acts as a connective link to all life and beings. That same spiritual force lends direction, purpose, and energy to human endeavors. Attunement to and enhancement of the spirituality that constitutes the core of our existence potentiates individual and collective healing and well-being.

Interconnectedness – An essential feature of the NTU philosophy is its "systems focus." The individual, group, family, community, and all animate and inanimate entities are viewed as integral parts of a larger, interdependent system. All elements and levels of systems have common properties and a shared inclination towards systems harmony.

Authenticity – Within the NTU philosophy, the highest value lies in person-to-person interactions and relations. The priority which is assigned to the value of relationships places a premium on one's ability to be genuine. It is the capacity to be true to ourselves, even in our relationships with others, that brings fulfillment.

Balance – The principle of balance implies both a state of equilibrium and an ongoing process of mediating competitive or opposing forces. When balance is achieved, a positive influx of energy is made available to the individual/system such that the conditions for harmonious living can be established and maintained.

Similarly, the principles of Nguzo Saba enable the client, as well as the practitioner, to isolate and focus on specific behaviors relative to enhanced interpersonal functioning from an Afrocentric perspective. The principles of Nguzo Saba are as follows:

Umoja (Unity) – To strive for and maintain unity in the family, community, and nation.

Kujichagulia (Self-Determination) – To define ourselves, create for ourselves, and speak for ourselves.

Ujima (Collective Work and Responsibility) – To build and maintain our community together and make our brothers' and sisters' problems our problems, and to solve them together.

Ujamaa (Cooperative Economics) – To build and maintain economic enterprises and to profit from them together.

Nia (Purpose) – To make our collective vocation the building and developing of our community and to be in harmony with our spiritual purpose.

Kuumba (Creativity) – To do as much as we can, in the way that we can, in order to leave our community more beautiful than the way we inherited it.

Imani (Faith) – To believe with all our hearts in our parents, our teachers, our leaders, and our people.

This cultural framework has allowed the program to view mental health problems among African Americans as "interpersonal" rather than "intrapsychic." One can see that just this small shift results in a different definition of and orientation to mental health problems. Services are then developed that are compatible with the cultural patterns and rhythms of African Americans. Therefore, for example, interventions are more visual, more action-oriented, based more on interactions and relationships, and more spiritual. The normative structure for interventions becomes the family or group, not the individual. The goal becomes "healing" rather than "curing," and there is a shift away from the individual deficit model to a collective strength orientation. African Americans are very relationship-oriented; the ability to bond and support each other (extended families) has been a survival mechanism since slavery.

Family as the primary system of support and intervention

The PLC also adheres to the culturally competent principle that "family," as defined by the culture, is the primary and preferred point of intervention. Family is defined by the client and includes those who are perceived as caring about the individual's growth and well-being. Thus, family may include an unrelated boyfriend or male in the home, adopted relatives, neighbors, church members, or friends. With this approach, PLC has found that there are always persons whom the client can identify. The therapist then makes every attempt to include these "family" members in the treatment process.

Given the importance of the family, the PLC has expanded the concept of assessment to include an analysis of family psychological functioning. Assessments are conducted in the home and in-home family therapy is the primary model of intervention. The center also provides multi-family retreats for families.

The PLC has developed a specific set of services for parents to reinforce the strength of the family and parenting skills. The parenting assistance sequence, How Empowerment Liberates Parents (H.E.L.P.), is designed to empower parents with skills, information, and peer support as they face the economic, psychological, and emotional challenges that accompany the difficult task of parenting adolescents. Through the PLC, parents are afforded a nurturing and stimulating

forum in which to receive "on-the-job training" reflective of their sociocultural values, needs, and priorities. The Parenting Seminar is the main feature of the sequence and it involves monthly, mealtime sessions in which parents engage in didactic and experiential group activities focused on common areas of concern.

Two other aspects of the parenting sequence serve to reinforce the gains achieved by parents as a result of their consistent participation in the parenting seminars. "The Family Way" is a monthly newsletter distributed to parents as a means of keeping them current on seminar discussions, community events, and personal milestones experienced by PLC staff and clients. The other part of the sequence is the Parents Advisory Board. This board is comprised of parents who successfully complete the seminar sequence and who are available to serve as a support and linkage to those parents currently involved in the program. The feedback provided to PLC staff by the Parents Advisory Board contributes to the process of ongoing program modification and development.

Importance of cultural assessments

Since it is believed that cultural values are passed down through families, the PLC assesses family psychological health in order to understand the influence of cultural values. PLC has developed and utilizes an instrument which allows the therapist to focus on the systemic issues of family process. This assessment yields valuable psychodynamic information concerning the level of family functioning, patterns of interaction, styles of communication, and areas of strength. For instance, questions are asked about family "rituals" and family values. Since the instrument has not been validated, the PLC also utilizes a battery of more traditional family instruments such as family sculpturing, genograms, FACES III, Draw-A-Person, and Pairs (a measure of marital stability).

In almost all cases, interviews are conducted with as many members of the family as possible. The emphasis in the assessment is on interpersonal relationships and how they might be improved rather than on individual or family pathology. The PLC staff would like to improve and validate the indicators and measures currently utilized in their family assessments. Staff are also interested in developing an assessment instrument that will measure levels of self-esteem and "psychological blackness" among African Americans, since these concepts seem to determine the outcome of many therapeutic interventions.

Concept of responsive services

The culturally competent principle of responsive services suggests that service delivery match the needs and help-seeking behavior of the client population. As noted earlier, PLC has based its service interventions on being responsive to the unique needs of African Americans. Although the treatment interventions are not new, the emphasis on inclusion of cultural values is. For example, in-home family therapy sessions are designed to facilitate family stabilization and healing; the sessions may focus on either ongoing or crisis-oriented concerns. PLC in-home family therapists utilize a number of culturally appropriate methods and techniques throughout the course of treatment including: joining, role modeling, reflective listening, alter ego, psychodrama, guided imagery, family structuring, hypnotherapy, and other culturally-enhanced

applications of the more traditional approaches to therapeutic intervention. Videotaping is often utilized in family therapy as an empowerment tool and enables the family to view and process various patterns of interaction and family dynamics that often go unnoticed in traditional treatment settings.

The multifamily therapy retreat is another example of the development of responsive services. The retreat is a structured communal experience designed to intensify the curative factors normally operative in the treatment process. The rural setting, multiple staff involvement, extended clinical intervention, and structured activities cohere to provide a unique opportunity for diagnostic and therapeutic insights. The goal of reinforcing and exposing families to more functional and alternative interactional patterns is achieved through this concentrated experience.

Multifamily retreats occur on a semi-annual basis. The retreat takes place at a 1,200-acre resort and conference center located in the mountains of West Virginia. The resort is equipped with modern sleeping accommodations, prepared meals, and recreational and conference facilities. Round-trip transportation is provided for families from their respective residences to ensure a high degree of attendance and to alleviate the stress and anxiety associated with travel. Participants in the family retreat consist of parents/guardians and the identified adolescent.

One of the more innovative and unique programs offered by the PLC is the Adolescent Rites of Passage sequence. This group process builds upon the concept of the young man's passage from childhood to manhood. Through a very formalized process in which skills and knowledge are acquired, the adolescent gains the prerequisites of manhood in his culture. The PLC Rites of Passage sequence is also offered to African American girls. The sequence involves three phases. The first phase, the Rites of Incorporation, is an intensive retreat experience designed to orient youth to the goals and expectations of the Rites of Passage program, facilitate peer bonding, and enhance cultural awareness and social skills. The activities for the retreat typically include spiritual rituals, Nguzo Saba activity stations, family meals, group discussions, music and education videos, personal journal development, therapeutic recreation, and aspects of manhood/womanhood training.

The second phase, Peer Group Development, is a group therapy component that consists of weekly sessions focused on various issues related to the cultural, family, school, and social experiences of the participants. The group provides a forum in which the participants accomplish interpersonal learning, information sharing, and social skill development. Specific knowledge is transferred via group discussion and structured presentations. Participants who successfully complete the peer group development component enter into "initiate" status and receive an African name as they prepare for the Rites of Passage Ceremony.

The Rites of Passage Ceremony is the final phase. Participation in this event denotes that the youth has demonstrated a certain level of cultural and social maturity, as determined by parents, therapists, and other significant adults. The ceremony provides an opportunity for celebration of this accomplishment by everyone in the youth's psychosocial milieu. It also provides an opportunity for the youth to demonstrate newly acquired skills and abilities in a culturally and socially supportive setting. The ceremony itself involves a variety of artistic and cultural expressions, words of encouragement from members of the community, demonstrations

of skill by the initiates, the crossover ritual, and welcome and charge to the initiates by the elders. It concludes with a Kinship Karamu (family feast).

For youth at the juvenile facilities, PLC therapists make the major assumption that many of these adolescents become involved in crimes and other antisocial behavior because they have become emotionally numb and cannot feel or empathize with their victims. The goal of treatment, therefore, is to reconnect the youth with his feeling, spiritual self and thus begin the healing process. Within this framework, there are certain techniques that appear to be very responsive to the needs of this population. Two techniques are hypnotherapy and creative visualization. Using these techniques, youth in individual sessions are relaxed and asked to re-experience the crime they committed. Certain factors in the crime are changed or rearranged so that a different outcome might result. Youth are also asked to experience the crime through another person or through the victim. These techniques are very powerful and often awaken an emotional response that has been buried within the youth. When there is an emotional response, therapists know that the technique is working. These and other interventions illustrate the PLC's approach to the development of responsive services to match the needs of the population it serves.

Working with natural, informal support systems

Given the philosophy of collective responsibility and support, it should not be surprising that PLC staff participate in numerous community activities. PLC staff have, over the years, developed an extensive community network. They provide services to churches, participate in radio and television talk shows addressing subjects of interest to the African American community, and participate on community and government task forces. In addition, the center sponsors at least eight activities a year in which the larger community is invited. These include Kwanza celebrations, community picnics, lectures, and open houses. The Rites of Passages ceremonies are held in community churches and are attended by many community leaders and residents. Therefore, the PLC and its staff are effectively integrated in its community.

These and other relationships increase the availability of resources for PLC clients. PLC staff have utilized ministers, psychic healers, astrologers, nutritionists, herbal experts, and other natural healers revered in the African American community when appropriate. They have also invited some of these persons to make presentations to staff or to serve the center in a consultative capacity.

Staffing patterns and ethnic composition

At the time of the site visit, the PLC had 30 full-time staff. This staff included 25 clinicians and 5 administrative persons. The array of clinicians included 5 Ph.D. psychologists, 10 MSW social workers, 5 masters-level psychologists, 1 masters-level person in family counseling, and 4 masters-level persons with counseling degrees. The administrative staff is headed by a Director of Administrative Services and includes receptionists, secretaries, a billing clerk, and a part-time audio-visual technician. The PLC also utilizes consultants on an as-needed basis. All of the staff at the PLC are African American, African, or Caribbean. The average age for the staff ranges from 30 to 35 years.

There has been a conscious decision on the part of PLC founders to hire only people who have advanced degrees and who are committed to working full time. These decisions were based on the fact that PLC is operating out of a coherent philosophy and treatment approach that must be adopted by every staff person. The types of training and interventions to be learned were believed not to be as effective with part-time staff. The decision to hire only those with advanced degrees was viewed as a marketing tool; it also would provide academic and professional legitimacy to the NTU therapeutic approach. It is important that PLC therapists be well trained and regarded as competent by the mainstream society and by other professional African Americans. PLC staff members have been trained in a variety of mental health models including behavioral, psychoanalytic, cognitive, and humanistic. These different orientations make for interesting approaches to the overriding NTU philosophy.

The NTU philosophy leads to a different conceptualization of the role of "therapist." In the PLC, the therapist is viewed as a "guide" and "healer" rather than as a person who provides answers and stringent directions. The therapist is viewed as an enabler, someone who assists in empowering the individual to live and create a more positive and rewarding environment. In this regard, the treatment process is a participatory one, relying on action and activity rather than strictly on verbal communication and thoughts. The PLC staff show the utmost respect to the clients and attempt to limit the "intrusive" aspects of therapy. In many ways, PLC staff become members of the extended family for clients.

Cultural competence training

The PLC has a well-developed and highly effective training department that offers both inservice training for staff and makes training available to other agencies and organizations. The training department's functions are consistent with the organization's matrix structure. As such, the training services are not only rendered by specific departmental staff, but are also conducted by the full complement of PLC professional staff. This pool of human resources is a strong asset to both PLC and the clients since competence, creativity, and multiple expertise merge in the creation of quality training products. The PLC training department is distinguished by its effectiveness in the provision of training and consultation services based upon a model of service delivery which emphasizes cultural competence.

The PLC does not expect staff to come to the agency knowledgeable about the principles of Nguzo Saba or NTU psychotherapy. Rather, it is expected that competence in this type of psychotherapy will be obtained through extensive training, practice, and continued knowledge transmission. All new staff receive 16 weeks of intensive training in NTU psychotherapy and Nguzo Saba principles. In addition, each staff member is expected to videotape a session with a client and present it to his/her peers for feedback on the technique and style used. These tapes are extremely effective teaching tools. Also, there are ongoing clinical training meetings once a week. The staff is also required to participate in an annual agency retreat and other staff activities related to experiencing the concepts upon which PLC is founded.

PLC also sponsors a Master Lecture Series in which renowned professionals on African American culture or Afrocentric issues present a lecture for staff and invited community guests. These lectures provide a forum for further clarification and validation of an Afrocentric approach

to service delivery. The PLC staff is in the process of exploring the possibility of a certification program in NTU psychotherapy. The NTU Psychotherapy Training Institute is envisioned as one in which trainees spend an extended period on site receiving both didactic and clinical experience. Trainees would have to demonstrate competence in the model through a written examination, a videotape of a case using NTU principles, and an oral presentation/discussion with a peer review process. As indicated earlier, the PLC also provides training in cultural issues to parents through H.E.L.P. and to many of its adolescent clients through the Rites of Passage sequence.

Understanding the dynamics of difference

Operating from a cultural base often places the PLC in direct conflict with many of the values and practices of the dominant American society. In order to function, the PLC must be conscious of these situations in which cross-cultural differences occur and work to resolve them in a positive and productive manner.

There are many examples of how cross-cultural conflict occurs and how important it is to understand the dynamics of difference. For example, many new staff have had to work out conflicts between NTU psychotherapy and their graduate training which was obtained in mainstream colleges and universities. Another example of potential cross-cultural conflict surfaces around funding for services. When the PLC first began, there was a conscious decision made by the board not to accept or seek funds that would, in any way, restrict the agency from meeting its mission of developing the NTU model on which it was founded. For that reason, the agency has no funding from the United Way or other similar funding sources. The board also made a conscious decision not to apply for reimbursement as a Medicaid agency since, at the time, Medicaid had a very strong medical model philosophy that was incompatible with the types of services delivered under the NTU model. Now that Medicaid has expanded coverage to include in-home services and other therapeutic services that are not dominated by the medical model, the PLC is exploring the option of becoming licensed as a Medicaid provider.

The areas in which cross-cultural conflicts become manifest in the PLC can be summarized as follows:

- Trying to operate Afrocentrically in a Eurocentric environment and the conflicting pressures that occur because of these conflicts. For instance, staff are paid in dollars and at different levels of compensation.
- Maintaining a balance between being progressive and becoming so radical that the PLC becomes isolated and removed from the larger society.
- Continuing to identify revenue sources that allow for the center's theoretical expression and orientation and will not be overly restrictive to the further development of the model.
- Attempting to operate internally using philosophical principles and values not accepted in the larger world or by other agencies.

- Attempting to market the concepts and services upon which the PLC is based. In order to do so, more effective evaluation information must be obtained which is hard to do when so many research-oriented studies and evaluations are based on principles that are antithetical to the NTU approach. There is a need to develop new research models.

Minority participation at all organizational levels

Since all of the staff at PLC are African American or of other African descent, the agency meets the principle of inclusion of minorities in the planning and administration of its programs. Internal policies and staffing issues are handled within the PLC Executive Committee that consists of the director and all division chiefs.

The external policies of the PLC are governed by a five-member Board of Directors. These policies include general administrative procedures, salary levels, capital purchases, and other decisions that affect the structure, assets, or directions of the center. Board members also provide professional management and consultation. All members of the board are African American. According to the by-laws, the board members are elected annually. There is no limitation on the number of years that a board member can serve. The board meets on a quarterly basis.

Support of self-determination for the broader minority community

The development of a minority-owned agency is, in itself, contributing to the self-determination of the African American community. The Nguzo Saba principles incorporated into the philosophy of the PLC also address collective responsibility for enabling the self-determination and self-sufficiency of the African American community. The program provides a model of positive economic development for minority businesses.

The agency also teaches the concept of self-determination to its clients and families. Through the Rites of Passage, adolescents are taught the concept of contributing and giving back to the larger African American community. Parents are also taught to become more effective advocates for their children and the African American community in general.

Several parents, along with PLC staff, have become involved in advocacy activities related to drug abuse prevention, better schools for their children, and other issues of importance to the African American community in Washington. Parents involved with the PLC often make presentations at meetings and other public forums in the District. For example, when the mayor called a meeting of his top cabinet members to address the increased drug-related arrests and homicides among African American adolescents, parents and adolescents from the PLC addressed the mayor and his cabinet. They were quite articulate about their own experiences and made extensive recommendations to the city officials. These and other activities enhance the functioning and esteem of the individuals as well as the community.

ROYBAL FAMILY MENTAL HEALTH SERVICES
UTAH STREET SCHOOL CO-LOCATION PROJECT
Los Angeles, California

At the Utah Street School Co-location Project of the Roybal Family Mental Health Services, the staff must be bilingual/bicultural, since it is believed that the benefits of therapy and other forms of intervention cannot be achieved through a translator.

Brief History and Identification of Agency

The Roybal Family Mental Health Services is one of approximately 15 outpatient mental health centers that is operated by the local mental health agency (Los Angeles County Department of Mental Health). It is located on the same site as the Roybal Comprehensive Health Center, one of several health centers operated by the local health agency (Los Angeles County Department of Health Services). The center was named after Edward Roybal, a local Latino/Hispanic resident who is currently a member of the U.S. House of Representatives. It is located in East Los Angeles, a large working class community predominantly composed of Mexican Americans. The Roybal Family Mental Health Services is staffed by minority staff to serve the minority community.

From the opening of the center in 1981, mental health services have been an integral part of the services offered. The mental health clinic currently provides diagnostic evaluations; individual, group and family therapy; crisis intervention; psychiatric assessments; medication therapy; psychological testing; and mental health consultation to significant social agencies such as the schools and protective services. The location of the clinic within a health services agency has tended to reduce the stigma and shame associated with mental health care for Spanish-speaking populations.

In 1987, the Roybal Mental Health Clinic expanded its services to include an on-site, school-based mental health program with students identified by the local education agency as being in need of special education services under the new California law, AB 3632, the state's enactment of P.L. 94-142. This law mandates greater coordination between mental health facilities and school districts in providing services to children identified as educationally handicapped due to severe emotional disturbance. Children identified under AB 3632 are entitled to all educational and mental health services stipulated in their individual educational plans (IEPs). The Roybal Mental Health Clinic, through its Utah Street School Co-location Project (USSCP), is one of the few programs in Los Angeles that provides school-based mental health services to minority children under AB 3632.

Community Description

The USSCP is located in a school and community that is primarily comprised of two large federal housing projects, the Aliso Village and Pico Gardens. The area has a high crime rate due to drug-related activities and gangs. There are 10 active gangs (9 Latino/Hispanic, 1 African American) within these projects and gang warfare and police/gang confrontations are the norm. There are over 2,400 families residing in these projects, 90 percent of which are Latino/Hispanic. This area is adjacent to downtown Los Angeles' skid row area; besides gangs, there are also large pockets of homeless and runaway populations. Due to gang activities and drug trafficking, the elementary children at the Utah Street School are no strangers to violence.

Within the school, almost all the teachers are white and non-Spanish speaking. There is only one school counselor for the 900 children in the school; the counselor also does not speak Spanish. The school population is reflective of the community-at-large: 90 percent Latino/Hispanic, with the remainder of the student population composed of African American, Asian, and Native American children.

Target Population

The target population for the USSCP are those children who are seriously emotionally disturbed (SED) and who require mental health services to function adequately in the educational environment. At present, the Roybal mental health staff provide structured, intensive mental health services to 14 students in the school. These students range from 10 to 14 years of age. There is a disproportionate identification of boys (12) to girls (2) in the project. Most of the children are in the fourth to sixth grades; their academic performance is generally far below the state average in reading, writing, and math skills. Most of these students have been involved in some type of special education since the first grade.

At the time of the site visit, eight of the children were Latino/Hispanic, five were African American, and one was Native American. Ninety percent lived in single-parent homes. Approximately 60 percent of the children resided in the nearby public housing projects. In order to receive mental health services, the students must receive a DSM-III-R diagnosis. Seven were diagnosed with an oppositional disorder, four received an attention deficit disorder diagnosis, and one each received a diagnosis of adjustment disorder, conduct disorder, and dysthymic disorder. Almost all of the students were considered extremely aggressive and difficult to manage.

Program Philosophy and Goals

The program philosophy at the Utah Street School is consistent with the overall Roybal Mental Health Clinic which has a family-focused perspective. This perspective stresses the need to treat the whole family rather than single individuals. The approach often involves extended family members and is predicated on helping people articulate and examine themselves rather than just telling them what their problems are. The importance of understanding the language and culture are paramount to this treatment philosophy and approach.

Services

The school-based mental health staff at Utah Street School provide screening, mental health assessments of families and children, group therapy, individual therapy, collateral/family therapy, and medication therapy.

The project coordinator attends weekly meetings with the school staff and provides consultation as needed. There is a monthly meeting to review progress of individual children and resolve any difficulties that may have arisen in the school. The school principal, psychologists, and teachers participate in some parent meetings and complete simple goal behavior progress report forms on each child. The children who are seriously emotionally disturbed spend at least a few hours daily in the specialized mental health classroom, but are also integrated into other special education classrooms and activities. These children are also encouraged to attend the summer program offered by the mental health staff and school. The summer program consists of a tutorial program, group therapy, socialization, and field trips.

Funding

The current budget of the Roybal mental health clinic is $1.2 million. Of this, $72 thousand is spent on salaries for the USSCP. The three main funding sources are the state's general mental health fund (Short-Doyle funds), state categorical funds (AB 3632), and Medi-Cal. Services are offered to families on a sliding scale unless they have Medi-Cal or private insurance. The students and families served at the USSCP are not billed since AB 3632 eligibility entitles them to the needed services.

Program Efficacy

The evaluation of the efficacy of services and of consumer satisfaction is conducted informally. One facet of the evaluation is the progress made by the client and family based on the treatment plan. Other measures of program efficacy include academic improvement, fewer behavioral problems in the classroom, better attendance, and fewer suspensions. The majority of the children served by the USSCP have shown significant improvement in these measures. The school principal, recently remarking about the changes noted in the children and families served by the USSCP, stated, "The children are more open, more responsive. Their parents are more trusting. In my past experiences, these parents were not trusting of the schools. I feel they are more trusting now because they see some positive changes in their children."

Cultural Competence Principles

Acknowledgement of unique issues of bicultural/bilingual status

The Roybal Mental Health Clinic was especially established to address the issues associated with bicultural/bilingual status of poor, Latino/Hispanic families in East Los Angeles. The co-location of mental health services, first within a health clinic and then within a school, demonstrates an understanding of the way that mental health services are perceived by the

Latino/Hispanic community and seeks to minimize the family shame, disgrace, and discomfort that often accompanies the seeking of such services. Instead of setting up free-standing mental health facilities, the integration of these services into multiagency service settings has reduced the reluctance of families to utilize these services.

The USSCP also addresses another significant access problem, the access of minority children to special education services under the California law AB 3632. Under the provisions of this law, the state mental health and education agencies are to coordinate their respective services for students identified as seriously emotionally disturbed. The mechanism for this identification of children is a collaborative effort between the two local agencies. Given the inadequacy of the level of funding and the entitlement nature of the program, both schools and mental health agencies have been reluctant to identify students. In the county of Los Angeles, a preponderance of middle-class children have gained access to these specialized services because of effective advocacy networks. Few of the minority families in East Los Angeles have such resources and are not knowledgeable about the law and its intent. Therefore, while 80 percent of the school population in Los Angeles County is minority, 53 percent of the children identified under AB 3632 are white. The resulting shift of these mental health resources away from poorer communities and minority clients was unanticipated when the law was passed by the state legislature.

The Roybal USSCP recognizes that unless special arrangements and/or considerations are made, access to services by ethnic minority populations will be significantly restricted under AB 3632. Factors which limit Latino/Hispanic children's access to these specialized services include minimal parental involvement, families' tenuous relationship with local schools, limited English proficiency on the part of some parents, and limited knowledge of the service systems. The Roybal USSCP has improved accessibility by sending mental health staff into a school with large proportions of minority students and by working with the school staff to assist in the identification of students in need of these specialized services. Although small, the Utah Street School is one of very few schools in Los Angeles County that has focused efforts on the identification of minority students under the new state law. It is hopeful that other schools in Los Angeles will follow this model of improving accessibility of specialized services to children of color who are in need of such services.

Incorporation of cultural knowledge/preferred choices in practice and policymaking

Bilingual/bicultural staffing at the USSCP has added a critical dimension to the interpretation of the behavior of minority children and their families. Since the mental health staff are the only bilingual Latino/Hispanic staff in the school, they are often able to consult with teachers and other school personnel on cultural factors that may be affecting the children's attitudes, behaviors, or ability to learn.

Group and individual psychotherapy sessions allow the children opportunities to comment upon, question, and reinforce cultural traditions and values. For instance, during holidays such as Christmas or Thanksgiving, the children discuss culturally-unique foods and customs that are observed in their homes. Most have never had a chance to discuss the differences between their

practices and those of the dominant society. By discussing these with other students and the staff, the customs do not seem nearly so strange and a greater appreciation of their culture and that of others is gained.

Familiarity with the culture of the students has also contributed to the staff's ability to reach families and to improve their relationships with the children. For example, the staff understand the composition and expected roles and functions of mothers in Latino/Hispanic families, as well as attitudes towards authority and mental health. Therefore, staff can conduct home visits that are non-threatening and that allow the parents to have a more positive response to the service their child is receiving. Oftentimes, the mother will not make critical decisions without input from the male figure in the home. Although this contrasts greatly with the roles of women in mainstream American society, it is important to respect this view when family involvement is needed. Since the staff are aware of these cultural values, they have been able to make inroads with these families and explain issues in a way that they can hear. In addition, visits and frequent telephone calls to parents about their child's progress have helped to eradicate the negative connotations often associated with calls from the school.

The staff have also been able to discuss topics with the children on an individual basis that are often not discussed openly. With their understanding of the culture and the pressures for certain types of behavior, staff have been able to address children's reactions to pervasive violence and gang activities, sexuality, pregnancy, death of friends, and their futures. Staff have been able to offer advice based on the contextual environment of the children and their families. Thus, meaningful changes in the behavior and choices of the children have occurred.

Family as the primary system of support and intervention

Outreach to families is considered a critical component of the Roybal services. When the USSCP began, the Roybal staff held a series of workshops and meetings at the school site for families in the area. The goals of the workshops included offering an explanation of the school-based project, of the AB 3632 educational law, and of other related services. Many parents attended these workshops; this resulted in many requests by parents for mental health services. However, given the limited mental health staff at the school site and the implicit attention focused on children who are seriously emotionally disturbed and their families, referrals often had to be made to the clinic site approximately five miles away. Predictably, many parents simply did not follow up. The orientation and USSCP workshops indicate that Latino/Hispanic parents have a great interest in acquiring information, but may be reluctant or unable to commit to long-term services if these services are not easy to access.

Parents are always included in determining the goals of the treatment and educational plans for their children. Although the on-site staff seeks to provide family therapy, there has been difficulty in getting most of the families to come to the school. The community worker and staff try to complete at least one home visit for each student in the program. However, the parents are often reluctant to have staff visit their homes for fear of having to deal with the stigma associated with visits by social workers from the local welfare office. The on-site staff seek to maintain contact with families through regular phone calls and written notes. Occasionally, or

during a crisis, parents will come to the school and meet with staff. As noted earlier, it is important that interaction with the mental health workers be sanctioned by the culturally-defined head of household.

Importance of cultural assessments

The Roybal staff acknowledge the importance of understanding the client's level of acculturation and assimilation. They recognize this as a component of the assessment of individual children and families and of the school as an institution.

When a child is referred to Roybal for an assessment, the clinic policy is that the family, not the school personnel, must call to make the appointment. In this way, the staff is given an opportunity to talk with key family members and to determine their attitudes and knowledge of mental health care. These family meetings may be held at the school or at the Roybal clinic. The insistence on the family's initiation is not often understood by the school personnel and often delays the completion of the assessment process. However, Roybal staff have found that when a family follows through, a more positive and sustained therapeutic alliance often occurs.

This initial contact also provides an opportunity to elicit cultural information that is often missing in the assessment of the child by the schools. Information about the level of acculturation, length of time in the country, country of origin, knowledge of the Los Angeles community, and use of other resources such as priests, curanderos (healers), and espiritualista (spiritualists) are important components in the Roybal assessment process. These, along with an exploration of linguistic skills and belief systems within the family, provide the cultural context in which to understand and serve the child and family. If the family is found to have, for example, a high level of disenfranchisement, a community worker is assigned to the family to familiarize its members with services available and to assist them in understanding their rights. The community workers are usually paraprofessionals with a very strong knowledge of the resources and culture of the Los Angeles Latino/Hispanic community.

Concept of responsive services

Through co-location of services and bilingual/bicultural staff, Roybal seeks to respond to the needs of Latino/Hispanic children in the schools and larger community. Further, as a part of the services offered the children, the staff have attempted to respond to the needs of the students for better interactive and interpersonal skills. One of the group therapy sessions is a socialization program where the children learn to improve their communication and social skills with their peers. Through playing games and other informal activities, the students learn to interact with others in socially appropriate ways. This particular component of the program utilizes a behavior point system that allows the students to measure their compliance with basic social skills. The staff have also been able to influence the way teachers and other school personnel approach and view these children, thus reducing the number of suspensions and incidents in the school environment.

Working with natural, informal support systems

Natural helpers are often discussed in the context of understanding the cultural values and beliefs of Roybal clients. Certainly the use of paraprofessional community workers assists clients in integrating mental health therapy with other belief systems and other helpers in their lives so that the use of several sets of helpers is not viewed as incompatible.

Originally, the Utah Street Project planned to provide an after-school program for its students. Due to a lack of security on the school grounds after the school day, this component of the program was discontinued. The project coordinator has looked to the natural helpers and resources in the community to support students in the program who are seriously emotionally disturbed. An after-school program is now being planned at the Dolores Mission Catholic Church which is located a few blocks from the school. The program will have substantial support and input from the priest, Father Gregory Boyle, who is an avid community activist on gang-related activities; he has spearheaded the development of an alternative school for gang members on church grounds and has invited them to become members of his parish. There is also a Boys Club in the area that is utilized for organized sports activities. Big Brothers is also available, but currently has a one-year waiting list for Spanish-speaking mentors. The mental health staff attempt to continually update their knowledge on local resources for children.

Provision of an integrated network of services

The Roybal Mental Health Clinic, from its inception, has provided consultation and other services to local schools serving large numbers of Latino/Hispanic students. The USSCP model is an especially visible method of bringing mental health services into natural settings for children and their families. Not only does the project address mental health services in a school, but concurrently addresses mental health services delivered in a public housing project. All of the constraints and benefits of this model are illustrated.

The project has evolved into an important component of the services offered children who are severely emotionally disturbed in Utah Street School and has become a model to other schools within the county and state. The relationships between the mental health staff, the teachers, the school administrators, and the school psychologists and counselor have become strong and mutually rewarding. The principal noted that an important factor is that the mental health team came in and worked in concert with the school staff; the services offered are integrated with the educational services rather than being viewed as "add-ons." Now, mental health staff have been accepted by school staff as "being with them" in working with, and helping, students with special needs.

The on-site mental health staff also consider themselves case managers for the 14 children who are severely emotionally disturbed in the program. As such, they also interact with child welfare agencies, probation officers, protective services workers, and other professionals involved with the family or child.

Staffing patterns and ethnic composition

The Roybal Mental Health Clinic is staffed almost exclusively by Latino/Hispanic bilingual staff. According to the director, the staff must be bilingual because it is believed that effective therapy and therapeutic relationships cannot be established using a translator. So, one of the first prerequisites in recruitment of staff is that they be bilingual (Spanish speaking).

Although it is difficult to recruit Latino/Hispanic men in mental health, the male presence is extremely important in Latino/Hispanic cultures and the lack of adequate male staff in mental health is often a barrier, especially to reaching fathers and other key male persons in the family. At the time of the site visit, the project had a project coordinator, who was a Latino/Hispanic male social worker, and a full-time Latino/Hispanic female social worker. In addition, ten hours of a Latino/Hispanic community worker from Roybal were available to this project. The Utah Project's having a strong, professional Latino/Hispanic male as the project coordinator made it somewhat unique. Further, the male/female staffing at the Utah Street School provided positive Latino/Hispanic role models for these children, many of whom had no sustained and positive male role models and were not used to interacting with professional Latino/Hispanic women.

The director of the Roybal Mental Health Clinic provides overall supervision and direction to the staff. The psychiatrists associated with the clinic review and authorize treatment plans for all children and families, including those at the USSCP. They also monitor medication, when prescribed.

The Roybal Clinic treatment philosophy dictates that staff must operate flexibly with respect to role definitions and functions. The needs of the clients define the type of services provided. Thus, sometimes staff must be advocates, interpreters, extended family members, educators, and negotiators in addition to carrying out their functions as therapists and case managers. Persons that find it difficult to live with such role diversity may find it difficult to be effective in this delivery system.

Understanding the dynamics of difference

Living with the dynamics of difference is an important aspect of the USSCP. By definition, the schools are a mainstream organization with values and policies which, at times, are not compatible with the cultural practices of Latinos/Hispanics and other minority cultures. The relative isolation of school staff from Latino/Hispanic students and their families, due to language barriers and cultural differences, was poignantly illustrated in this program. Until the Latino/Hispanic mental health staff became involved as negotiators and mediators, much distrust existed between the school staff and families as well as between the school staff and the children. Much of this distrust came from a basic inability to effectively communicate with each other and from differences in communication styles. The mediator role of the project staff often served to improve the school's relationship with the families in the community.

The importance of the funding source must also be carefully considered in establishing programs for ethnic minority populations. Very restrictive funding is quite a challenge to a

mental health service agency which attempts to provide a variety of services. Recent shifts in mental health funding in Los Angeles County towards the SED school population are not conducive to meeting the multiple needs of the Latino/Hispanic families served by the Roybal Mental Health Clinic. In order for mental health and other needs to be met, outreach to families, greater parent education and support, early intervention, and other preventive measures are all important service elements – some of which have different funding streams, if any.

Finally, the ability of Roybal staff to understand the intragroup differences within Latino/Hispanic populations and to understand the critical differences between someone who has recently immigrated to Los Angeles and someone who has been in the United States for several years, is extremely important. For example, in providing crisis relief during a recent earthquake in Los Angeles, staff were able to understand why the trauma was more pronounced for those who had recently immigrated from Mexico City as compared to those from other Spanish-speaking countries or to those who had resided in the United States for many years. For recent Mexico City immigrants, the earthquake was a reliving of terror associated with earthquakes in Mexico City and subsequent losses and deaths.

Minority participation at all organizational levels

The director of the Roybal Mental Health Clinic is Latino/Hispanic. The Roybal Clinic philosophy espouses that management and line staff should share cultural and linguistic backgrounds similar to that of the client population. Unless management has some knowledge and experience with bilingual/bicultural issues, it becomes difficult to supervise staff or answer questions around the cultural aspects of engagement and treatment.

The local mental health agency has a Children's Citizens Advisory Committee which advises local agencies in regard to child mental health issues and concerns. This committee, however, does not directly advise the Roybal Family Mental Health Services. Therefore, an advisory body was organized to provide input to the administration of the Roybal center. This advisory body includes a high school principal, a mental health counselor, a mental health regional office staff person, and a teacher. Four of the members of the committee are Latino/Hispanic. The committee meets every other month and discusses the status of Roybal programs. About a year ago, when mental health went through a budget curtailment process, the committee was very supportive to the Roybal staff and advocated for staff and for specific programs.

SANTA CLARA COUNTY MENTAL HEALTH BUREAU
San Jose, California

The guiding principles of the Santa Clara County Mental Health Bureau incorporate the belief that effective services for minority populations must "take into account their unique world views, socioeconomic status, and the external stressors precipitated by the burdens of discrimination and cultural attitudes and beliefs about mental health." The level of acculturation plays an important role in the assessment process and treatment planning.

Brief History and Identification of Agency

The Santa Clara County Mental Health Bureau is located within the Department of Health. The agency is the authority established to provide mental health services to the over 1.3 million people in the county. A wide range of mental health services for adults and children are provided through a combination of county-operated and contract agencies. For mental health planning and service delivery, the county is divided into four mental health regions. The Mental Health Bureau has also organized its services into three subsystems: the Acute Services Subsystem, the Community Mental Health Subsystem, and the Community Support Subsystem.

Due to a number of converging factors, the Mental Health Bureau has been actively involved in improving access and the availability of mental health services to the ethnic populations within the county for more than 15 years. The initial impetus for the development of greater cultural awareness and sensitivity in the area of mental health began in 1969. At that time, strong advocacy actions were taken by a community-based Chicano Mental Health Association. This group was concerned about the lack of culturally and linguistically appropriate mental health services available to its community. This concern provided the impetus to develop a strategic advocacy plan which would address long-term inequities of mental health services for Latinos/Hispanics. At a later time, African American and Asian American community groups joined in a parallel effort, thus forming a strong coalition of advocacy groups with a common goal of bringing attention to the needs of underserved ethnic populations.

Around the same period, the bureau submitted a proposal to the National Institute of Mental Health (NIMH) and received funding to hire 22 minority paraprofessionals and indigenous workers. At the time, the county had few administrative or professional treatment staff who reflected the ethnic makeup of the population. These paraprofessionals were an initial link and bridge between the ethnic communities and the county mental health system. Since that initial phase, the county has continued to develop its ability to meet the needs of its ethnic minority populations and has made substantial progress.

The administration of mental health services is centralized in San Jose. The administration is responsible for planning, policy development, data collection and statistics, contracting and

operating service programs, and research and evaluation. The Mental Health Bureau represents a mainstream agency supporting services by minorities within minority communities.

Community Description

Santa Clara County, located at the southern tip of the San Francisco Bay, is known familiarly as Silicon Valley, the center of the semi-conductor and computer industry of the United States. This valley is the birthplace of pocket calculators, home computers, cordless telephones, laser technology, microprocessors, and digital watches. It is the nation's ninth largest manufacturing center. On many social indicators, Santa Clara County surpasses the state of California and other United States' counties in mean household income, in percentage of its population who are college graduates, in percentage of population in family households, and percentage of those who reside in one-family dwellings.

The population mix in the county is unusually diverse. At one end of the county is Palo Alto, home of Stanford University, and an expansive upper middle-class professional community. At the other end is the other major city within the county, San Jose. San Jose has a large Latino/Hispanic population and has been a central relocation site for Latinos/Hispanics, Southeast Asians, and Native Americans. Santa Clara County, like most of California, has experienced a major growth in ethnic minority populations. In 1980, the county's ethnic minority population as a whole was 29 percent; it had increased to 37 percent by 1990. The largest ethnic population is Latino/Hispanic (18 percent), followed by rapidly growing Asian and African American populations. There is also a small percentage of American Indians. These ethnic groups are plagued with major educational, economic, human, and community development problems – as they are across the nation.

Target Population

Most of the clients utilizing Santa Clara County mental health services are poor. The majority of the clients are single or female heads of household between the ages of 25 and 54. A substantial number are unemployed or disabled. Within each region, higher treatment rates occur with lower educational attainment. The major diagnostic groups are depression, anxiety, schizophrenia, affective psychosis, and adjustment reactions. Approximately 25 percent of the county's population are children under the age of 18.

The target population for the ethnic minority activities at the Mental Health Bureau to date are Asians, African Americans, and Latinos/Hispanics. Each of these groups has different needs, as identified by demographic and utilization data available in the county.

At the current time, Asians represent about 12 percent of the Santa Clara County population. Currently, at least 11 different Asian languages have been identified. As a group, Asians tend to fall into two distinct categories: those who are now settled and are in fourth and fifth generations (primarily Chinese/Filipinos) and those who are considered recent refugees and immigrants (primarily Vietnamese, Cambodians, and Laotians). The need for mental health services is very different for these two groups. The acculturated Asian groups are usually seen

in the general treatment programs and have very low levels of mental health need. The Asian refugees are usually seen in specialized mental health programs. Generally, all Asians are underrepresented in the mental health system.

The African American community represents almost 4 percent of the county's population. However, its members represent over 7 percent of the patients in the mental health system. African Americans tend to be overrepresented, especially in mental health services associated with the Acute Services Subsystem (i.e., inpatient, emergency, crisis, and criminal justice mental health services). Of the African American clients served in the Acute Services Subsystem, almost 46 percent were served in the criminal justice component, especially in jail.

Latinos/Hispanics in Santa Clara are also a significant and rapidly growing group. They constituted almost 18 percent of the population in the 1980 census. The majority come from Mexico (78%), Central and South America (19%), Puerto Rico (3 percent), and Cuba (1 percent). This population has the least education and exists in an economically disadvantaged condition in comparison to non-Hispanic groups. Over 40 percent of the population is under age 18, which is the highest percentage of children in any racial/ethnic group. Approximately 12 percent of the population lives below the poverty level, compared to 5 percent of the total county population. Latinos/Hispanics are significantly underserved by all of the mental health subsystems in Santa Clara, however they tend to be overrepresented in the criminal justice system, especially in juvenile detention facilities.

It should be noted that children have been identified as a group in need of additional mental health resources and services. Not only are they currently underserved, but the number of children in need of services is actually increasing. In order to address the specialized needs of children, the bureau is reorganizing its Community Mental Health Subsystem and will have a distinct Division of Children and Families to address the mental health needs of all children in the system.

Program Philosophy and Goals

One of the major goals of the Mental Health Bureau is to develop and improve services for the ethnic minority populations within the county. In the development of quality services for these groups, it is a program philosophy that services must be fashioned to address the individual as a member of his/her ethnic group and must coincide with the client's world view. Also, mental health services need to impact on the socioeconomic stressors experienced by the individual within the context of his/her family and community.

In order to accomplish these goals, the Mental Health Bureau began the process of conducting community surveys on the general population and/or specific ethnic minority populations. The surveys were used to assess the level of mental health needs within a particular group and to determine utilization of mental health services. In 1980, the first general population survey was conducted as well as one focused on populations of Mexican origin in Santa Clara County. In this survey, the mental health staff found a high level of depression among people of Mexican origin, especially women. Also, immigrant status was highly associated with increased

levels of depressive symptomatology. Questions on the survey about the use of mental health services showed Mexican-American cohorts to be low users of these services. The Mental Health Bureau has also completed a community survey of the four major Asian groups in the county.

Although these community surveys supplied a wealth of data and information about the population and about the level of mental health needs, a method was still needed to translate the results of the survey into goal-setting for services by the bureau. In 1982, the medical director, Dr. Ken Meinhardt, developed a method and began to apply it to goal-setting. There are two concepts important for understanding the method and how it helps to establish service goals.

The first concept is "*parity.*" Parity refers to a goal of having the treatment population reflect the same minority percentages as the population of the county. For example, if Latinos/Hispanics constitute 16 percent of the county population, then a parity goal would be to have 16 percent of the patients served by county mental health services be of Latino/Hispanic ethnicity. Parity is rarely reached in public mental health programs, but it is widely cited as an appropriate goal.

The second concept of importance is "*equity.*" Equity as a goal is defined as reaching minority populations in accordance to their relative need as well as to their percentage in the population. In this case, for example, the 16 percent of the population which is Latino/Hispanic should be weighted in some fashion that takes into account relative need. For the Mental Health Bureau, this relative need is obtained from the community surveys. The equity method has been adopted as the measure for goals established by the Mental Health Bureau and is believed to have several advantages. It is easily understood, it is obviously objective, and it is scientifically valid. It provides quite specific, measurable goals for each sub-population. The mental health staff have found that these goals have been widely accepted not just by minority services advocates but also by the majority population.

Although needs assessment is crucial to defining service levels of need, it is only one of the first steps. Needs assessment cannot address the types of services needed or the ways in which services must be organized to be accessible and acceptable to the various ethnic populations. In order to effectively implement services, the Mental Health Bureau has developed several intentional interventions: inclusion of minorities in the planning of new services, i.e., formation of an Ethnic Populations Services Task Force; development of a specific hiring plan; creation of new agencies and services; and shifting in the priorities of existing agencies.

Services

The services of the Mental Health Bureau are decentralized throughout all regions of the county. In each region there are services for children, adults, the elderly, and the homeless. The amount and variety of these services depends on the socioeconomic status of the community and the availability of private sector resources or contract agencies. It should be noted that the services are proportional to the percent of the population in need of public, county mental health services.

These services include inpatient and emergency care, mental health criminal justice programs, community mental health outpatient and day treatment programs, case management, membership club programs (psychosocial rehabilitation), vocational day programs, rehabilitation mental health services, housing/residential programs, day and night shelter services, homeless outreach and advocacy services, senior residential services, and in-home support. The bureau also provides children's day treatment, intensive day treatment, outpatient and residential treatment, and services for those in juvenile detention.

Funding

The Mental Health Bureau has a budget of almost $70 million. Fiscal responsibility for services depends on state and county resources. Santa Clara is one of the more affluent counties in the state and has been able to rely on increasing county revenues to cover decreases in state funds for mental health over the last few years. Continued budget cuts will have some impact on the county's ability to continue to address the program goals for ethnic minority populations. However, many of the minority-specific goals do not depend on major increases in new funds from the county. Rather, the plan depends upon filling with minority group members the positions of people who leave the staff and pursuing other avenues of funding, such as federal grant programs.

Program Efficacy

One of the strongest components of the Mental Health Bureau is its program evaluation and research activities. Much of this is due to the interest of the bureau leadership over many years and/or hiring staff that are focused principally on these activities. Another facet of this strength is the bureau's strong cooperation with universities and colleges in the area in the pursuit of research grants and collaborative studies.

The mental health system is being evaluated through service utilization studies. One utilization study in progress during the site visit was examining several factors affecting the utilization of services by ethnic population adults. This project was looking at differences in utilization for each service function as well as at differences in utilization with respect to major factors such as education, diagnosis, and income. Another service utilization study was completed in September 1989. This study looked at the effect of ethnic matching of therapist and client and its impact on the length of treatment and/or service utilization patterns. The results of the study show that matching the ethnicity of client and therapist has a positive impact on the length of treatment and also reduces the client's use of emergency and inpatient services. The staff responsible for program evaluation and research activities are continuously expanding their efforts to include more specific studies of ethnic minority populations.

CULTURAL COMPETENCE PRINCIPLES

Acknowledgement of unique issues of bicultural/bilingual status

The Mental Health Bureau believes that in order to develop more effective services for ethnic minority populations, services must take into account their unique world views, socioeconomic status, external stressors from the burden and discrimination associated with being a minority, and cultural attitudes and beliefs about mental health. The experience of being an identified minority in a majority culture always takes a significant psychological toll.

Further, although language differences are important to take into account in the development of services, it is equally important to recognize the biculturality of each group, including African Americans. The fact that the African American community maintains a very distinct culture which is not congruent with the dominant culture is not widely accepted by members of the dominant society. However, all these groups are bicultural and cultural differences as well as language differences must be taken into account when planning services. For example, merely having Spanish language capabilities does not make a program culturally compatible for clients.

The community surveys undertaken by the Mental Health Bureau have shown that there are different levels of mental health needs in the various ethnic minority communities in the county. Survey results show the following percentages in each group:

Chinese (non-refugee)	5.1%
White	5.6%
Mexican American (English preferred)	9.1%
Chinese (refugee)	11.7%
African American	12.0%
Vietnamese	12.9%
Native American	15.4%
Mexican American (Spanish preferred)	15.9%
Cambodian	34.0%

However, many of these groups do not utilize mental health services in proportion to their needs. Often, members of ethnic population communities are unfamiliar with the availability of mental health services. In addition, from the communities' perspectives, mental health services may have a negative connotation or the services, as they have been traditionally delivered, may be irrelevant. To address this, several methods of outreach and education need to be incorporated into the system's services.

Incorporation of cultural knowledge/preferred choices in practice and policymaking

As noted earlier, the Mental Health Bureau established an Ethnic Populations Services Task Force to assist in the development of short- and long-range goals of the bureau in relation to ethnic minority populations. The group consists of ethnic minority providers and advocates from

the Asian, Latino/Hispanic, and African American communities within the county. Task force members were selected for their knowledge of their respective population group and for their commitment to using their skills to develop a vision of how ethnic populations as a collective group and as unique populations should best be served by the county mental health system.

As a part of its report, the task force identified nine principles that should guide and form the basis of the bureau's strategy in this area. These principles reinforce the notion that knowledge of the cultures and preferred choices should inform practice and policymaking. The nine principles are:

- Equity goals – A commitment to an equity goal for each ethnic group is a critical element of the system's partnership with these communities.

- Treatment philosophy – The quality of services can be strongly enhanced by a treatment philosophy that responds to the individual as a member of his/her ethnic group. The client's treatment needs to affirm and coincide with his/her world view.

- Systems of care – The services must be organized as a comprehensive, coordinated system of care for each group.

- Staffing – Staff that can deliver services that adhere to the treatment philosophy must be hired, trained, and retained by the mental health system.

- Outreach and education – These activities must be incorporated in the system's services.

- Early detection and intervention services – A partnership with the ethnic population community demands an approach that detects the need for services and intervenes with treatment at the onset of the individual's and the community's symptoms.

- Representation at policymaking levels – There must be representation of the three ethnic groups in the system's highest levels of management and decision making.

- Advocacy – The mental health system, functioning as a partner with these communities, must publicly advocate regarding issues that have a negative impact on the mental health of these communities.

- Goals of treatment – Progress, optimism, and success are essential concepts that must permeate the system's partnership with ethnic population communities.

Importance of cultural assessments

Through its community surveys, the Mental Health Bureau has shown the importance of understanding culture and ethnic group differences in the attitude towards and use of mental health services. Thus far, the bureau has assessed the Mexican American and Asian communities. Now, the bureau intends to develop a community needs assessment of the African American

population in Santa Clara. There are also plans to update the previous studies of Latino/Hispanic and Asian populations, especially as the demographics of Santa Clara County shift. The American Indian community would like to have a community survey conducted for its population as well.

In addition to ethnic community assessments, the Mental Health Bureau believes that, on an individual level, the ethnic minority's acculturation status must play an important role in the assessment process and in treatment planning. Acculturation refers to a complex process whereby the behaviors and attitudes of an ethnic group change toward the dominant group as a result of exposure to a cultural system that is significantly different. Therefore, the bureau has established a group to work on the Acculturation Project. This includes the development and design of an acculturation instrument that is suitable for African American, Vietnamese, and Latino/Hispanic clients. It has been decided that these instruments will be used to assess the level of acculturation among new clients seeking mental health services in several agencies serving primarily African American, Latino/Hispanic, and Vietnamese communities over a six-month period of intakes. The results of these assessments will then be analyzed in relation to need for services, to amount of service received after intake, and to various other diagnostic and demographic indicators. Once these instruments have been validated, they will be utilized as a component in the assessment process.

Concept of responsive services

As noted earlier, services for ethnic minority populations must be responsive to their needs. The Ethnic Populations Services Planning Task Force suggests that the system must:

- Encompass the services that collectively have the capability of meeting the needs of the community at all degrees of cultural identification
- Utilize primary treatment therapists to work with each individual and family on a continuous, as-needed basis
- Be presented to the community in a manner that affirms and coincides with the world view of the ethnic group
- Be delivered in locations and use approaches that make the services a part of the community and, thus, have the ability to be responsive to its needs
- Coordinate and link with other mental health system services, other government and community agencies, and community-oriented groups

On the individual client level, mental health services should increase self-esteem and self-understanding, improve and develop the survival skills necessary to function within the client's community and culture as well as in the mainstream society, and ensure independence from institutions.

As a part of ensuring more responsive services, the bureau has established several agencies and programs with a specific focus on an ethnic group. These include:

Asian Americans for Community Action (AACI) – This advocacy group has evolved into a major provider of direct social and mental health services for all Asian groups. It provides specific mental health outpatient services for Vietnamese, Cambodian, and Laotian refugees. Services include an Adolescent Day Treatment Program.

The Josefa Narvaez Mental Health Center – This is a county mental health center which was developed in an area of the county with large numbers of Latinos/Hispanics, Vietnamese, and Cambodians. The center program was built around services to these groups.

El Centro de Bienestar – This is a new division of a general health clinic (The Gardiner Center). It targets Latinos/Hispanics and was developed in the central area of San Jose to serve monolingual as well as bilingual Latinos/Hispanics. An in-home support and case management program for Latino/Hispanic seniors was also established.

The Las Plumas Center – This program was opened in 1988 in east San Jose, an area of barrios (slums), to serve mostly minority children living in that region.

El Pico – This is a day treatment program for severely disturbed adolescents which was opened in a high school in east San Jose.

The Mekong Social Center of the Vietnamese Catholic Community – Opened in 1989, this is a small program that offers case management and social supports to Vietnamese refugees that are homeless, or virtually homeless.

La Casa del Puente – This is a community residential program for seriously mentally ill Latinos/Hispanics. It includes respite and permanent living arrangements provided by the Bridge, Inc.

Indian Health Center – Mental health outreach and evaluation services are provided at a community health center primarily serving the American Indian community.

African American Youth Program – Recently developed, this program offers a family-focused, home-based case management service for African American youth involved, or at-risk of involvement, with the juvenile justice system. These services are provided by the Bay Area Association of Black Social Workers.

Asian Pacific Inpatient Program – This program provides culturally relevant inpatient services to the Asian Pacific population of the county through a specialized unit within county-operated inpatient services.

Socorro Hispano, Latino/Hispanic Inpatient Program – This inpatient unit provides short-term psychiatric treatment within a hospital setting to patients of Latino/Hispanic background.

The bureau is also in the process of expanding specialized services for ethnic minority populations based on the recommendations from the Ethnic Populations Services Planning Task Force. In addition to the development of specific services to address targeted ethnic minority populations, the bureau has also begun to review existing agencies and providers. Through the affirmative action reporting of all agencies and through a focus on bilingual/bicultural staff capabilities, already-established agencies have increased their capacity to respond to emerging needs of growing minority populations. Mainstream outpatient, day treatment, and 24-hour treatment agencies have all registered an increase in minority services.

Working with natural, informal support systems

The bureau employs a large number of paraprofessional staff. Often these staff are used by individual programs to forge relationships with the informal networks within various cultural communities. These types of activities are strongly encouraged.

In conducting community needs assessments, extensive education of the community has to be done. The bureau usually hires and trains interviewers from the indigenous communities. The interviewers, as well as bureau staff, must spend time within the community. For example, when the Asian survey was conducted, staff met with many Asian community groups, spent weekends at temples and lunar celebrations, and had to be flexible in their time. Mental health was represented by persons, not institutions. In each community, it has been found most useful to personalize mental health as a service.

Provision of an integrated network of services

There is a conscious effort to coordinate the delivery of mental health services with other agencies. For instance, the bureau provides extensive mental health services to the criminal justice system, including probation. These relationships are long and ongoing.

Many of the programs for children, especially day treatment, are located in schools. Therefore, there is strong interagency cooperation with the educational system. The linkages with education are becoming even stronger with the implementation of AB 3632, the new special education/mental health law that guarantees mental health services for children identified through the special education process as being emotionally disturbed. Some level of mental health services are currently provided at 36 different school sites.

The bureau also has informal interagency agreements with the Department of Social Services and a unique agreement has been made regarding shelters for children and adolescents. There also is an ongoing liaison with the alcohol and drug abuse agency, since there are many dually-diagnosed clients. This ongoing relationship includes joint assessments and training of each

other's staff around understanding the impact of drugs/alcohol on the client's condition, treatment, and mental health.

Staffing patterns and ethnic composition

Awareness of staff competence and ethnicity is an important component in operationalizing a culturally sensitive delivery system for ethnic populations. The Santa Clara County Mental Health Bureau has established a policy that the ethnic composition of the staff in various programs should reflect the ethnic population of the clients served. Therefore, conscious efforts and activities have been undertaken to meet this goal.

At the time of the site visit, the Mental Health Bureau had a staff of 672 persons. Almost half (355) were professionals, usually involved in the treatment of clients. There were also 66 technicians, 107 paraprofessionals, and 3 administrators in the organization. Almost two-thirds of the staff was female (63 percent), over half was white (52 percent), followed by Latino/Hispanic (19 percent), Asian (17 percent), African American (12 percent), and Native American (1 percent). Although this represents substantial employment of ethnic minorities, the distribution of these groups over the various occupational categories is very uneven. For example, there is only one ethnic minority administrator (Latino/Hispanic) out of 10 positions, and 60 percent of those in the professional category are white. However, a large proportion of those in paraprofessional or service-maintenance positions (68 percent) are ethnic minority.

In 1985, the bureau developed a bilingual certification policy. There is a mechanism in place to test and certify staff as bilingual in the following languages: Spanish, Vietnamese, Cambodian, Laotian, Cantonese, Mandarin, and Sign. Bilingual certification provides a small increase in salaries of mental health professionals. When there were proposed cutbacks in staff, the bureau was successful in identifying key positions that should be filled by bilingual staff and in maintaining a large number of the existing bilingual staff despite seniority requirements. It is believed that this policy becomes more effective when certain staff positions are clearly identified and allocated as positions that must be filled by bilingual/bicultural staff and the bureau is moving towards this approach.

The bureau has also hired an Ethnic Populations Services Specialist. The State of California had developed a policy that encouraged each county to establish such a position. The coordinator for Santa Clara, Maria Lucero, is Latino/Hispanic. She has primary responsibility for developing a plan for increased ethnic population services and for ensuring that all activities at the bureau incorporate the concerns and issues of ethnic minority populations at the highest levels of policy and administration.

The bureau has found that affirmative action, though useful and consistently applied in hiring in the county, is not sufficient to develop an adequate level of staffing for increased levels and improved quality of clinical services for ethnic minority groups. Therefore, as a part of the deliberations of the Ethnic Populations Services Planning Task Force, the bureau's affirmative action and personnel staff developed an Ethnic Populations Recruitment and Retention Plan. The purpose of this plan was to delineate a strategy for the active recruitment, retention, and staff

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development of minorities and other groups. The resulting strategy has both short-term actions and long-term goals. The plan has outlined the following objectives:

- To achieve equity representation of underrepresented minorities in administrative, professional, and technician categories in each subsystem program.

- To protect affirmative action gains already made in these categories and to monitor the hiring process to ensure ongoing compliance.

- To initiate staff development planning to increase retention of minority staff and improve career mobility of protected groups where they are underrepresented.

- To promote contract agreements with Bay Area universities and colleges which will support the field placement of minority student interns in bureau mental health programs.

- To develop cooperative and supportive links with ethnic population groups that promote mental health services to underserved populations.

- To establish a consistent working relationship with county personnel for facilitating recruitment strategies and identifying employment codes which require hiring of underrepresented groups.

Understanding the dynamics of difference

Since the Mental Health Bureau is dealing with so many different ethnic minority groups, the dynamics of difference are always present. The dynamics of difference arise in three situations in Santa Clara: differences within an ethnic group, differences between the ethnic groups, and differences between the ethnic groups and mainstream groups.

For example, in the community survey each of the Asian groups was very different and showed great disparity in its immigration experiences as well as in its adjustments to this country. The surveyors found that depression and demoralization were repetitive themes in the Asian interviews and characterized those who admitted to high levels of psychological stress. However, the Cambodian population showed elevated percentages in moderate- and high-need categories, as compared to the general population and to other Asian groups. About 18 percent exhibited high need. No population group yet surveyed has approached the Cambodian level of psychological distress and dysfunction. The pre-1975 Vietnamese resembled the general population, while the post-1975 Vietnamese sample showed significantly increased proportions in need of mental health services. Despite refugee status, the Chinese refugee group did not have quite the same elevation of need scores as the other Asian groups. The non-refugee Chinese had notably lower percentages of individuals in need of mental health services. Without understanding the levels of need and dynamics of difference between the groups, it would not be possible to develop responsive mental health services.

There are often differences between the ethnic groups, usually due to the fact that they all compete for attention and funding. To decrease the conflicts resulting from the dynamics of difference, the ethnic minority populations in Santa Clara have met as one body rather than fragmenting their efforts through inter-ethnic conflicts. All of the groups recognize that they have common concerns as well as those unique to their ethnic population. Due to reasoned and committed leadership, these ethnic groups have been extremely supportive of each other and have not been involved in internal dissension over inadequate resources. Therefore, the plans that have developed for each specific ethnic group are strongly supported and advocated for by the other ethnic groups as well. Oftentimes, the dominant society can be very instrumental in setting up interracial and ethnic in-fighting for small amounts of resources. In Santa Clara, this has not occurred.

Finally, although mainstreaming services for ethnic minorities is considered positive, some of the minority advocates are skeptical about mainstream agencies receiving funds to develop services for ethnic populations. They believe that if cutbacks are necessary, the white agencies will have little commitment to the services for ethnic populations, and these services will be the first to disappear. However, the need for both mainstream and minority-specific agencies to address the service needs of these populations is clear.

Minority participation at all organizational levels

The Mental Health Bureau has sought to ensure that there is participation from ethnic minority groups at every level of the organization. The bureau has adopted a policy that supports these activities at the highest levels of its organization. The bureau has also engaged numerous ethnic minority professionals and involved them in decisions concerning its many planning activities associated with the effort. To coordinate these activities and to ensure that they remain on the agency's agenda, the bureau has hired an Ethnic Population Program Specialist whose primary responsibility is to implement the minority initiatives.

The bureau has also established a planning process that includes significant and major input from persons within ethnic minority communities. The communities must develop and "buy-in" to the planning process. In order to do so, they must be assured and guaranteed that the time and effort expended will result in a plan that will be vigorously implemented. To maintain their commitment, the bureau has sought to hire ethnic minority staff in key positions. It has been somewhat successful in this effort.

Externally, the major governance structure that impacts on the policies and programs of the Mental Health Bureau and other county agencies are the county executive and the five members of the Board of Supervisors. At the moment, there is one Latino/Hispanic and one Asian among this group. The Board of Supervisors, although fiscally conservative, has proven to be a very humane and responsive group to the needs of various populations within the county. It has very strong Affirmative Action planning and hiring policies.

The Board of Supervisors also appoints a 15-member Mental Health Advisory Board which includes physicians, psychiatrists, psychologists, social workers, consumers, and others involved in mental health programs and policies. This board advises the Director of Mental Health. It meets once a month and has some responsibility for: program planning, the budgetary process, setting agency priorities, monitoring ongoing programs, and advocacy/legislative linkages. There are four minorities currently on the board – three Latinos/Hispanics and one Asian. Four years ago, the board also established a Minority Advisory Committee to review issues specifically related to ethnic minority populations in the county.

SOUTH COVE COMMUNITY HEALTH CENTER
Boston, Massachusetts

The South Cove Community Health Center locates mental health and physical health services together because many Asians share a holistic view of mind and body and therefore "often somatize psychological distress." Also, in keeping with cultural beliefs and the need to maximize service benefits, this center provides therapy in a manner that supports the child's connection with his parents' culture. The service providers seek to accommodate parents' work schedules, since many fathers are restaurant workers who must work weekends and nights.

Brief History and Identification of Agency

The South Cove Community Health Center (South Cove) is a private non-profit health clinic started in 1972 by a group of community activists who were interested in acquiring affordable and accessible health care services for residents of Boston's Chinatown. The health center started in a storefront in Chinatown with a pediatric team. In 1974, Tufts/New England Medical Center (NEMC) received funds from the National Institute of Mental Health to develop community mental health teams. Tufts/NEMC started a Chinese child mental health team and later transferred this to South Cove as a community-based mental health service for the Chinatown community. This complemented the adult program which began in 1976.

South Cove is a minority-owned agency serving minority clients. Currently, the center provides a wide range of ambulatory care services that include: pediatrics, obstetrics/gynecology, internal medicine, dentistry, eye care, family planning, health education, mental health, nutrition, podiatry, social services, and school health. In addition, South Cove provides medical, nursing, and home health services to five local elderly complexes throughout Chinatown.

Community Description

South Cove is located in the Chinatown section of Boston. Chinatown is very close to the downtown retail area and to the "red light" district, with its nightclubs and prostitution. It is also adjacent to the theater area and the recently gentrified South End. Like most Boston communities, the residents in Chinatown tend to be similar in ethnic and socioeconomic status. Chinatown is replete with Chinese and Vietnamese restaurants and other small businesses operated by Asian immigrants and refugees. It is considered a very close-knit Asian community and is a haven in which Asian languages and customs can be readily heard and seen. The health center is co-located with the Quincy School, a Boston elementary and community school which provides recreation, English training, and day care services. A senior citizens housing complex, primarily for Chinatown residents, is located next door.

South Cove's satellite program, Metropolitan Indochinese Children and Adolescent Services (MICAS), is located in downtown Chelsea. This part of Boston has been composed of working

class families, primarily of Irish or Italian descent. Recent mobility patterns have seen many of these families relocate to nearby suburbs, and Chelsea, Revere and other communities within the area now have large pockets of Southeast Asian refugee families. Most of these families live in overcrowded or poor housing, speak very little English, and have low-paying jobs.

Target Population

The target population for South Cove's mental health services is those Asians residing in Chinatown and other areas of metropolitan Boston who are unable to avail themselves of services due to language and cultural barriers. At the on-site offices, services are provided to adults, children, and families. The majority of clients are Chinese from Taiwan, Hong Kong, China, and Vietnam. Ninety percent of the population is made up of first generation Asian immigrants with little English language capacity. Fifty-three percent reside in federally designated medically underserved areas, 64 percent have incomes below the poverty level, and another 29 percent are near-poor. The great majority of the clients are restaurant or garment workers.

In the MICAS program, the majority of the clients are adolescents of Cambodian, Vietnamese, Laotian, or Amerasian descent who are identified through the school system and social services agencies. Most of them reside in pockets of refugee resettlement throughout metropolitan Boston. It is estimated that the Indochinese refugee community in the greater Boston area includes 25 thousand Cambodians, 18 thousand Vietnamese, and 7 thousand Laotians. A recent study of these populations found that a high percentage suffer from depression and severe anxiety. The study also found that a large number of Southeast Asians have experienced trauma due to the loss of a close family member or relative in an unnatural manner, due to victimization by the Khmer Rouge regime or Thai pirates, and/or due to the experience of being robbed, raped, or tortured. Other problems now being recognized in the refugee community are spouse and child abuse, drug and alcohol abuse, and large school drop-out rates. These problems are exacerbated due to the backdrop of trauma and cultural transition.

Program Philosophy and Goals

South Cove's mission is to provide affordable and accessible physical and mental health care to the Asian community in greater Boston, targeting low-income Asian immigrants and refugees as a priority population. Although specific activities and projects differ as South Cove's programs evolve and the needs of the target population change, the center adopted the following goals for Fiscal Year 1991:

- To maintain quality assurance that is culturally sensitive.
- To deliver a life-cycle concept of preventive health care.
- To provide culturally relevant services for the Asian community.
- To support health promotion and disease prevention targeting health problems relevant to Asian Americans.

- To provide continuity of care through partnerships and networking with "mainstream" systems of health care delivery.

- To expand recruitment and retention initiatives for bilingual and bicultural health care providers.

In mental health, these overall center goals translate into a treatment approach that recognizes the importance of the family, as well as outreach, advocacy, and support.

SERVICES

The South Cove mental health program offers a full range of outpatient services for children from birth to 18 years of age, as well as adults. These services include: psychiatric evaluations; individual, group, and family psychotherapy; marital counseling; psychological testing; case management services; outreach services; psychoeducational/day treatment services; emergency/crisis services; and educational support services. The full range of physical health care services are also available to all mental health clients, as needed. Off-site, staff operate the Brighton-Allston Afterschool Enrichment Services (BASE) for 24 school-age Asian children and an Early Intervention Program serving 30 high-risk children from birth to three years of age. Most of the families seen in these programs are Chinese. Under Chapter 766 of Massachusetts law which guarantees the right of disabled students to a free, appropriate, public education, the mental health staff also provide bilingual special education evaluations and consultations to over 15 schools in the Boston area.

The MICAS program operates as an outreach, community-based program for children, adolescents, and their families from Cambodian, Laos, and Vietnam. The program provides mental health, child welfare, educational support, and social services. Services offered include: individual and family assessment, individual and family therapy, educational counseling, intensive family intervention, crisis intervention, assistance with investigations of child abuse and neglect reports, information and referral, consultation and education, and advocacy. MICAS staff provide many of their services in several high schools throughout eastern Massachusetts where large numbers of Southeast Asian students are enrolled. MICAS also operates a specialized hospital diversion and inpatient psychiatric support service for children and adolescents called CONNECTIONS. CONNECTIONS provides crisis intervention, diagnostic evaluation, individual and family therapy, support services for family members, and case management to Cambodian and Vietnamese adolescents who are admitted to, or at risk of admission to, child/adolescent psychiatric hospital units in the greater Boston area.

FUNDING

In the last fiscal year, South Cove had an operating budget of $4.3 million. The mental health program at South Cove had a budget of $700 thousand, and MICAS had a budget of $800 thousand. Although a significant percentage of the costs associated with mental health are paid through patient fees and Medicaid/Medicare, mental health services are subsidized by funding

from the Massachusetts Department of Mental Health, Department of Public Health. The Department of Social Services funds the after-school components.

The MICAS program has 19 different funding sources. The greatest percentage of its funding comes from the Massachusetts Departments of Mental Health (45 percent) and Social Services (45 percent). There are also small amounts of funding from the Office of Refugee Resettlement, the city of Boston, and private foundations. In the MICAS programs, clients do not have to pay a fee for services.

Program Efficacy

South Cove is in the process of designing a formal program evaluation that will be tied in with quality assurance indicators. Data will be collected through random, periodic reviews of medical records by a clinical committee. The Quality Assurance Committee will also utilize the goals that are identified each year to measure the center's progress and program effectiveness.

A client satisfaction survey was conducted this year. The results indicated that a large proportion of the client population was satisfied with the services received. In addition, the clinic has been holding a number of community forums. These meetings have been well attended and have provided feedback about current services as well as about other health services needed.

Since the MICAS program is funded by the Commonwealth of Massachusetts, it submits monthly statistical data and has state program reviews. From this information, MICAS appears to be a very effective model for delivering services to Southeast Asian adolescents and families. The program has certainly increased the accessibility of mental health and social services to refugee communities. The hospital diversion program, CONNECTIONS, has also proven to be quite effective in reducing psychiatric hospitalizations, reducing inpatient lengths of stay, and in providing needed aftercare and case management services to prevent rehospitalization.

Cultural Competence Principles

Acknowledgement of unique issues of bicultural/bilingual status

Due to the bilingual/bicultural status of Asians in this country, as well as to the heterogeneity of the population, health and mental health services have been inaccessible due to language barriers and the lack of Asian professional staff. When services have been available, there have been serious issues associated with observations and labelling of behavior that differs substantially from that of the mainstream American society. Therefore, Asians have tended to avoid participation in American institutions and many of their problems have gone unidentified and unattended. It was this state of affairs that led activists in the Chinatown community to establish the South Cove Community Health Center. The health center was a direct product of the inaccessibility and unacceptability of health and mental health services to the Asian population in Boston. South Cove and its satellite program, MICAS, are currently two of the few mental health/social service resources for Asian children, adolescents, and families.

Mental health still carries enormous stigma and negative connotations in Asian cultures. Formal systems are seldom utilized when help is needed; rather, Asians tend to look towards community leaders and elders, extended family members, and natural healers and helpers in times of distress. Also, many Asians share a holistic view of mind and body and often somatize psychological distress. As a result, effective models for engaging Asian clients in mental health services would not emphasize a "stand alone" service. Therefore, both South Cove and MICAS play down their identifications as mental health providers to reduce the negative connotations and stigma often associated with mental illness. The co-location of mental health services within a physical health clinic or, as in the case of MICAS, within school settings, enhances acceptance of services and removes much of the stigma. This is because these settings have credibility and authority in Asian communities.

The language accessibility offered by South Cove is also critical. South Cove is located within a modern building that has signs in English, Chinese, and Vietnamese to guide visitors. In the waiting areas, there are books, magazines, and other literature in English, Chinese, Vietnamese, and Khmer. Information directs one to the various medical clinics or mental health/social services. There are also many posters and art decorations about events in Chinatown or denoting various Asian cultures. The clinic also provides babysitting services for parents.

Through their bilingual staff, South Cove also increases access for Asian clients to mainstream services. Staff often accompany clients to other mainstream service providers when interpretation is needed. Therefore, the agency provides a unique service to the schools, courts, hospitals, and social service agencies that have limited linguistic capacity and cultural sensitivity, but that are expected to respond to the needs of Asian American citizens, immigrants, and refugees.

Incorporation of cultural knowledge/preferred choices in practice and policymaking

In many ways, South Cove's policies and practices provide examples of culturally competent approaches to mental health treatment. First of all, the treatment program is based heavily on the premise that cultural values, beliefs, and choices must be integrated into service delivery. The program accepts the client's culture as it really is, without judgment, and adapts service delivery to fit the context in which the client functions.

The South Cove programs attempt to address the mental health needs of children, adolescents, and families, many of whom are experiencing the trauma of migration and acculturation. These traumas include: the pressures felt by Asian youth as they respond to two different cultures; the parent-child conflicts that ensue when children become knowledgeable in the language and customs of the United States and change the parent-child dependency relationships; adjusting to schools and other American institutions; coping with the depression, loss, and violence that often complement migration; and the rising incidence of child abuse, domestic violence, and substance abuse in the new environment.

The need for cultural knowledge and appreciation of the immigrant and refugee value systems is further complicated by the diversity within Asian groups. This presents a major challenge due to multiple dialects, different customs, and different immigration experiences. Therefore, it is important to understand the exact composition and makeup of the Asian community. For instance, a Chinese mental health professional may be unable to communicate with Vietnamese, Cambodian, and/or Laotian clients. It is often necessary to hire Asian professionals and workers from many different ethnic origins. In delivering services, the agency must also take into account the primary target population. Elderly Asians may find it difficult to respect young, inexperienced workers, and women may find it difficult to share confidential information about sex with an Asian male. If services are to be delivered effectively to meet the diverse needs of the Asian groups in the community, then it is important to know the target population and to understand the different values inherent in Asian cultures.

Family as the primary system of support and intervention

The South Cove therapeutic program is focused on treating the child within the family context and many types of activities are undertaken to gain and maintain family involvement. Also, due to the strong focus upon family within the Asian culture, it is almost impossible to provide effective services to children without gaining the tacit permission and approval of parents. Therefore, in order to engage families South Cove and MICAS therapists often deliver services in community-based settings such as restaurants or schools, or within the client's own home. The staff also engage the family in every aspect of the treatment, from initial history taking and assessments, to treatment planning and service provision, through the discharge process. Also, special groups, mostly educational in nature, are offered parents and family members on a routine basis.

Parents often have a hard time understanding that their child's problems require psychotherapy; rather, the child's behavior is usually attributed to physical or somatic difficulties. Therapy, therefore, must be "reframed" in such a way as not to undermine the child's identity with his/her parents and culture of origin. After intake and development of treatment plans, recommendations for treatment must be translated to parents in terms they can understand and accept. Since the credibility and authority of schools is highly regarded by most Asians, many times school staff cooperate and act as conduits for speaking with and convincing parents that the family should be involved in the treatment process. If a school recommends treatment, parents are more likely to "buy in" to the proposed treatment strategy. Psychotherapy methods are adapted as appropriate for cultural mores. For example, with Asians, respect for elders is paramount. Even in cases where parents are largely responsible for the child's problems, treatment cannot undermine respect for parents.

In addition, therapy must accommodate the work schedules of parents, since many fathers are restaurant workers who must work weekends and six days per week. These workers usually have Monday or Tuesday off, so family sessions must be scheduled during these days.

Importance of cultural assessments

South Cove staff believe that the assessment process must address issues associated with acculturation, migration, trauma, and assimilation when attempting to diagnose and treat Asian clients. It is also very important that the assessment process be conducted in the language in which the client is most comfortable. When a referral is made, a bilingual/bicultural mental health professional arranges to meet with the identified client and his/her family. This meeting may take place on-site, in a school, or at the client's home. Time is spent in taking a psychosocial history and other family information.

In addition, the worker gathers information about the family related to specific Asian experiences. For example, questions are usually asked about the length of time the family has been in the United States and in the particular community. Staff gather information about the country of origin, ethnic subgroup, and dialects spoken. The interview process also tries to solicit information about the migration and acculturation experience. Although there are no formal tools used to determine level of assimilation/acculturation, belief systems are evaluated. Such issues as adaptation (the extent to which one is becoming more and more Americanized), food preferences, religious/spiritual beliefs and practices, and family planning are considered in determining the degree of assimilation.

When children are the main client, the staff seek information from the schools and other agencies that may have contact with the child. If there are physical health issues, these are also noted in the intake process. Although South Cove has not developed formalized instruments for culturally based assessments, the Director, Dr. Jean Chin, has collaborated in developing a training manual for conducting more sensitive psychotherapy with Asian clients from an ethnic minority perspective.

Concept of responsive services

Since South Cove's services are predicated on understanding the client population, the center meets the principle of providing responsive services matched to the needs of its population. As noted earlier, bilingual/bicultural staff are critical. In addition, as has been pointed out, services are scheduled around the work hours of the family. Health education and counseling sessions are often held in the restaurants at which parents work and are scheduled before or after their working hours. The parents' desire to participate is heightened by these outreach methods.

Culturally determined attitudes about causes of physical and mental disease frame the way many topics are handled. "Folk" ideas are respected and can be incorporated into the treatment process. The treatment team often acknowledges that traditional healers/practitioners are being visited simultaneously.

MICAS staff have found that the key issue with their client population is trust. Since there are so many stressors associated with the acculturation process, it is very important that MICAS staff provide concrete assistance and help to gain the trust of the adolescent and the family. The dangers of retraumatization must always be considered in the therapeutic relationship as well.

For example, if a child needs to be placed in a foster home or psychiatric hospital, then care must be taken to avoid the fear that the child will not come back, causing another loss to be visited upon the family.

MICAS staff often provide educational information to their clients to help them better understand how to seek help. For example, CONNECTIONS staff recently developed a presentation entitled "Coping with Change" that is designed to encourage Southeast Asian adolescents to seek help with personal and family problems for themselves, their siblings, and friends. The presentation contrasts Southeast Asian and Western problem-solving methods and resources, describes common responses to trauma and cultural transition, and introduces some sources of help, particularly for youth in crisis. This workshop was presented to 274 Cambodian, Vietnamese, and Amerasian adolescents attending public schools in Boston, Lynn, Chelsea, and Revere.

Working with natural, informal support systems

South Cove also demonstrates the cultural competence principle of working in conjunction with natural, informal support and helping networks within the Asian community. Since mental health services are delivered within the context of Asian communities, the use of natural helpers and informal networks is ever present. Although therapists do not encourage or discourage the use of natural helpers, issues related to the kind of assistance they can provide often come up in therapy sessions and it is known that many clients seek help from the formal mental health system and the natural help system simultaneously.

Although South Cove does not utilize natural helpers directly, there have been some linkages between the two systems. Buddhist monks, herbalists, acupuncturists know that clients attend mental health sessions and that clients often incorporate both methods in their solutions to problems. Therefore, the South Cove therapists indulge in "benign participation" with natural helpers, but do not do cross-referrals. In the MICAS program, religious and spiritual elders, or people respected as being wise in their community, are sometimes utilized to complement services and to provide advice and consultations.

Given that South Cove/MICAS staff view their services as integral parts of the communities which they serve, substantial use is made of informal networks and resources. Center facilities are closed to observe Asian holidays such as the Chinese New Year. Also, center staff participate in community activities such as the Dragon Boat and August Moon festivals. As mentioned earlier, they also provide health education and outreach programs after work in restaurants. Each year, the center sponsors a health fair where screenings, outreach, and health education to the Chinatown community is provided. This activity provides an ideal opportunity for the center staff to interact with the Chinatown community.

Provision of an integrated network of services

Since South Cove offers services that are unique in the Boston area, there are many collaborative efforts with mainstream institutions to assist these organizations in better meeting

the needs of Chinese and Indochinese populations in Boston. The staff at South Cove provide innumerable services to the Tufts/New England Medical Center and other hospitals when it comes to understanding and treating Asian clients. Some of the staff at South Cove also have teaching appointments at Tufts medical school.

South Cove also has a number of affiliations with other colleges and universities in the Boston area, training students in social work and psychology. In addition, the MICAS program has developed a strong cooperative link with the Boston University School of Social Work through its special program for Refugee and Immigrant Paraprofessional Training. Almost all the caseworkers at MICAS have been through that training program.

The center has established strong interagency linkages with the Boston public school system. These linkages are especially important because Asians place such a high value on the education process and the stigma of mental health services is significantly reduced if services are offered on site at schools or are sanctioned by the education system. The center is co-located with the Quincy Elementary School and there are many collaborative undertakings based on this co-location in the Chinatown community. The center uses the school's gymnasium, cafeteria, and auditorium to hold board meetings, community meetings, recreational activities for children in the evenings, and parent groups. In exchange, physical and mental health services are readily accessible and available to children attending the school.

The MICAS program also provides critically important services to Southeast Asian students in key Boston public high schools. The program has on-site staff in four high schools: South Boston High School, Brighton High School, Lowell High School, and English High School. The staff work with school administrators, teachers, and students to address and resolve many of the problems encountered by the Southeast Asian population in American schools.

Both South Cove and the CONNECTIONS project provide an important service to mainstream hospitals, especially psychiatric services. The staff work closely with the hospital staff when Asian clients are admitted or at risk of admission. The staff provide interpreter services, consultation, crisis intervention, family counseling, and aftercare services to those being discharged. Prior to South Cove services being available, many Asian clients had a higher-than-average suicide rate and were being admitted to hospitals that could not communicate with them or their families.

Staffing patterns and ethnic composition

The South Cove on-site mental health program employs 14.75 full-time-equivalent (FTE) staff. All treatment staff are licensed psychologists and social workers who are bilingual/bicultural.

The MICAS program has a staff of 18.25 full-time equivalents. The four administrative staff in the program are all white, as are the 1.75 FTE support staff. There are 12.5 FTE treatment staff; 58 percent of this staff are Southeast Asian. In this program, the treatment staff consist of teams made up of a white MSW social worker and a Southeast Asian caseworker who is a

paraprofessional. Such a staffing pattern is not considered ideal, but reflects the lack of trained mental health professionals within Southeast Asian communities. Extensive training is available to the MICAS paraprofessionals.

The use of bilingual/bicultural Asian professionals is key to South Cove's model of culturally competent service delivery. The ability to deliver services in the client's primary language, without the intermediary of a translator, cannot be overstated as crucial to a therapeutic alliance. The use of Asian professionals reinforces the Asian community's perception that its system of mental health care is at least equal to what is available in the mainstream. At the South Cove on-site mental health program for Chinese immigrants, bilingual/bicultural professionals play a pivotal role in engaging and developing alliances with the client population. These staff provide the basis for examining and revising traditional western models of service delivery and/or improving access to care. Without such staffing, there would be no place for these immigrant families to receive help.

The use of indigenous paraprofessionals as caseworkers is also a unique aspect of the South Cove program. As noted earlier, the lack of trained mental health professionals from Southeast Asian populations has meant that MICAS has had to depend on paraprofessionals from within those communities. The employment of these bilingual staff as caseworkers from Indochinese refugee communities is a transitional model that might be explored and replicated by other communities when bilingual/bicultural professional providers are not available. This arrangement is not considered ideal, but is viewed as a temporary solution until more Southeast Asian professionals can be trained.

It is important to note that these paraprofessionals receive a substantial amount of training and supervision. Through collaboration with the Boston University School of Social Work, there are opportunities for these caseworkers to receive college credit and to pursue higher degrees, thus further developing human resource capacity for the Southeast Asian community.

Also, to promote and recognize the professional development of bilingual/bicultural caseworkers as they acquire knowledge, skills, and independence on the job, MICAS has established four levels of caseworker positions. Each level is accompanied by a set of competencies, providing a focus for supervision and training as well as facilitating evaluation. A caseworker must master 80 percent of the competencies at his/her level before being promoted to the next. This level system has allowed for increases in salary and responsibilities as the caseworker becomes more seasoned and competent in his/her work.

Cultural competence training

The South Cove mental health program conducts a training seminar once per week. These seminars have used the training manual developed by the director on providing psychotherapy to Asian Americans and have emphasized topics of empathy transference and countertransference, and issues unique to Asian service providers and clientele. Clinical staff also provide topical presentations that emphasize problems of child abuse, domestic violence, and seriously mentally

ill persons in the Asian community. The rethinking of traditional concepts of psychotherapy is emphasized in these seminars.

In the MICAS program, all staff must complete a two-week pre-service orientation. These orientation trainings have different foci for refugee and non-refugee staff. For the latter, this training focuses on non-verbal communication, on the refugee experience, and on an understanding of cultural values and beliefs. For the Southeast Asians, this pre-service training focuses on the basis of American ways of helping, on orientation to the system, on case presentations, and on seminars about various intervention techniques.

Understanding the dynamics of difference

South Cove staff recognize the dynamics of difference both within their own programs and in the relationship of these programs to mainstream agencies and organizations. Internally, as the Asian population in Boston became more diverse, the center had to grapple with the issue of providing services to these diverse groups; they spoke different languages and had health needs that differed from the predominantly settled population of Chinese immigrants in Chinatown. These differences spawned tensions often felt by South Cove staff, especially in funding situations. For example, although there has been increased spending on Asian groups in Boston, most of this new funding has been directed at Indochinese refugees and not at Chinese immigrants. External political factors also increase the competition felt between the Chinatown population and the refugee population for services and funding. Sometimes, for example, both MICAS and South Cove mental health programs compete for grants from the Commonwealth. Given the history of political and economic animosity between many Asian groups, it is understandable that some of these conflicts will surface when there are scarce resources. However, this complicates political support and advocacy for Asian services and leaves some tension between the primarily Chinese staff at South Cove and the Euro American/Asian teams at the MICAS program.

The dynamics of difference of the programs within South Cove must be understood in the context not only of the different ethnic communities served, but also of the different evolution of these ethnic groups as newcomers to the United States. Services to the Chinese community have developed over a longer period of time; those to the Southeast Asian populations are more recent.

Another example of the dynamics of difference can be seen within the MICAS program itself. The white professional/Southeast Asian paraprofessional team approach creates interesting dynamics within the agency and in the delivery of client services. Although the team concept implies two members of equal or close status, there are roles and functions involved in the relationship that are not equal. The Southeast Asian caseworkers are critical for entry and acceptance into the community, as well as for providing the ability to communicate with the client population. On the other hand, the white social workers have skills and negotiating powers that would not be available to the community otherwise. The staff at MICAS openly discuss and address these issues on an ongoing basis.

In an unpublished paper entitled "A Challenge in Supervision: The Culturally Diverse Agency," the Clinical Services Coordinator at MICAS and the Co-Director of the Refugee and Immigrant Training Program at the Boston University School of Social Work make some observations and suggestions about how this situation should be handled in agencies with similar staffing:

- There should be a recognition that there are many cultural barriers that face Southeast Asian staff who are employed in human service agencies. For instance, coming from a culture where "the helper" was structured into society, mostly by allegiance, whether it be an extended family member, an elder, or a monk, the word "social worker" means nothing. When these paraprofessionals are hired, who are, first and foremost, refugees and survivors themselves, they are asked to define "help" by Western standards and also to find a way in which to define themselves as "professional helpers." Often that definition is a contradiction in terms for those who come from a Southeast Asian culture.

- The agency needs to be very concrete in outlining the expectations for the bilingual caseworkers. The job description should outline this employee's role very carefully.

- Another consideration around staffing is numbers. It is common for agencies with a newly developed program to hire a single worker. This practice places a heavy burden on the bilingual caseworker. Invariably, the community places more demands on an ethnic worker than on an American provider and the workload increases. Hiring more than one ethnic staff, even if it is on a part-time basis, will dilute some of the demands placed on the single ethnic worker (as well as decrease the feelings of isolation).

- The supervisor selected to work with the program should be experienced and respected within the agency. This will assist in enhancing the stature of the bilingual worker. The supervisor should also be a part of the hiring process.

- The agency should also develop and implement training for the entire staff, professional and support, around the issues of the ethnic group to be served. The training should involve the assistance of community leaders. Topics covered should include a cultural overview, reason for migration, communication patterns, demographics, problems currently facing the group(s), and available resources within the community.

Minority participation at all organizational levels

Since South Cove is a minority-owned agency and is staffed with bilingual/bicultural staff, Asians participate at all levels of the organizational structure as therapists, administrators, and program planners. The one exception to this is the MICAS program where all supervisory and administrative staff are white.

South Cove operates with a highly effective and energized board of directors. There are 24 members of the board, 22 of whom are Asian. Several of the members have been on the board since the early community activist days when the center was first envisioned. Therefore, the board

members have a strong sense of history and are very committed to the center and the Chinatown community. Many of them grew up in Chinatown or have parents and family that still live there. The board includes physicians, accountants, professors, businessmen, human service providers, Chinatown civic leaders, and others who are very invested in services for the Chinatown community and for Asian immigrants and refugees.

One issue that the board is addressing at this time is its own composition. There is only one board member from the Southeast Asian community, even though the services at South Cove are rapidly expanding in that area. The board is reviewing options for rectifying this representation issue in the governance structure.

Support of self-determination for the broader minority community

The South Cove Community Health Center considers itself an integral part of the institutional structure of Chinatown and the larger Asian community. It was born out of community activism and concern about the needs of Asians and it continues to be a major advocate for many issues in the community. The agency, its board, and staff have proven very effective in advocating and lobbying for its constituency at federal, state, and local levels. These efforts have helped to publicize the needs of the Asian communities to legislators, state agencies and the general public. Due to these efforts, funding has been maintained so that services can be expanded and developed to meet the special needs of various populations. The advocacy efforts have also helped to illuminate the facts about the heterogeneity of Asian populations.

The MICAS program, through efforts such as its CONNECTIONS project with the Massachusetts Mental Health Association, has been effective in bringing the plight of Southeast Asians to the attention of the Massachusetts legislature. Each year a coalition of the Refugee Health Advisory Committee, the Massachusetts Association of Mental Health Advisory Committee, and the Massachusetts Immigrant and Refugee Advocacy Coalition holds a legislative briefing for Massachusetts legislators. These briefings have been quite effective in keeping the refugee issues on the legislative agenda. Staff from MICAS also testify on budget hearings and have succeeded in getting MICAS funded as a line item in the state mental health budget.

South Cove staff also attend meetings with civic leaders, neighborhood organizations, clan associations, and other planning groups interested in the continued economic and social development of the Chinatown area.

THREE RIVERS YOUTH
Pittsburgh, Pennsylvania

Three Rivers Youth, in its work with African American youth, has developed a family system approach to treatment because of a basic view that the natural family "is the most important formative influence in the child's development" and that the adolescent can best be understood within the context of family history.

Brief History and Identification of Agency

Three Rivers Youth (TRY) is a non-profit agency located in Pittsburgh (Allegheny County), Pennsylvania. It was organized in 1970 through a consolidation of the Termon Avenue Home for Children (founded in 1880 as an orphanage for "colored" children by the Women's Methodist Association) and the Girls' Service Club, a home for adolescent girls (founded in 1914 by the Junior League of Pittsburgh). The mission of the new agency was to provide a network of group homes for adolescents.

From 1970 through 1982, TRY developed a network of eight community-based group homes. The agency was able to purchase each of the residences, contributing to the stability of each unit within its neighborhood. In 1982, TRY was successful in obtaining funding as part of the Act Together national demonstration to implement model programs for high-risk adolescents. TRY designed an integrated service system based on past experience and assessment of the unmet needs of the adolescents that the agency had been serving. Since that period, TRY has expanded its services to include not only group homes but many other service components that meet the needs of high-risk children and adolescents.

Community Description

TRY is located in Pittsburgh, Pennsylvania. Over the last decade, the city has moved away from its over-reliance on steel mills and other manufacturing-related employment towards occupations focused on modern technological industries. Extensive urban renewal and renovations have led the city to be termed one of "the most livable" in America. Despite these massive changes in the occupational structure of Pittsburgh, the city is still considered conservative in its politics. Furthermore, there still remain many communities with very well-defined ethnic neighborhoods and residents.

TRY has experienced many problems and great community resistance to the establishment of community-based group homes for high-risk, often minority, children and adolescents. Despite overwhelming obstacles, TRY has managed to establish a cadre of group homes spread throughout various Pittsburgh communities. The homes are located in mostly middle class residential areas and there has been a conscious effort to locate them throughout the metropolitan area rather than in any one area. In this manner, the program has avoided the

"ghettoization" that often accompanies the development of community residences for deinstitutionalized populations.

Target Population

TRY's target population is high-risk adolescents and their families who have suffered severe abuse, neglect, or deprivation, usually from infancy through childhood. These adolescents have been victims of physical and sexual abuse, multiple rejection, and failure at home and in school. They have grown up without confidence in themselves or in the people around them, and they lack social, academic, and vocational skills. These adolescents have often not had the help they need to understand that they were not responsible for the abuse and pain they experienced as young children, and so they express their pain and anger in ways they have learned: withdrawal, drug and alcohol abuse, unsatisfying and hurtful relationships with peers and adults, early pregnancy, juvenile offenses, hostility, and aggression.

During 1988, the average age of a youth served by TRY was 16. There were more girls (73 percent) than boys (27 percent). Seventy percent of the youth were African American, 29 percent were white, and 1 percent was Latino/Hispanic. These gender and racial characteristics tend to vary slightly over time. Social service agencies placed 40 percent of the youth, probation agencies placed 8 percent, and 52 percent entered programs on a voluntary basis. Of those youth placed in 1988, 70 percent had been previously placed out of the home; some had as many as 24 prior changes of placement before being placed at TRY. During this same period, the average number of changes of placements for youth at TRY was four. Twenty-six percent had past psychiatric hospitalizations.

Program Philosophy and Goals

In the beginning, TRY adopted and utilized a psychodynamic approach to treatment, relying primarily on individual and group intervention. However, based on experience with the high-risk population and on work with families in the first eight years, the agency developed a family systems treatment approach. Later, this approach was supplemented with a behavior management system designed by the staff. The latter features a developmentally-based level system emphasizing the adolescent's sense of responsibility and involving the adolescent and peer group in strategic clinical thinking. Further, a strong educational diagnostic-prescriptive program, with educational advocacy for each youth, became an important aspect of the residential program.

The theoretical base for the treatment appr ach at TRY is threefold: developmental, psychodynamic, and learning. Developmental theory is used in ongoing treatment planning to understand the origins of the youth's behavior, to assess areas of cognitive, social, and emotional development, and to discover areas where there are blocks to development. Psychodynamic theory is the basis for TRY's family systems frame of reference, and learning theory forms the basis for TRY's educational diagnostic/prescriptive frame of reference. The TRY treatment approach is based on a framework of consistent confrontation of unproductive behavior in a therapeutic environment which transmits persistence, firmness, understanding, and caring.

Services

The integrated service system at TRY is comprised of a horizontal integration of programs and a vertical integration of services within all programs. The array of programs include: therapeutic group homes (males and females), residential teen parenting programs, an apartment living program, an Intensive Treatment Unit (coed), services for pregnant and parenting teens, an Alternative Educational Vocational Program (AEVP), day treatment, therapeutic services, and the Loft Runaway and Homeless Youth Program. The services include: individualized assessment, individual counseling, group counseling, outreach to families, academic support and remediation, vocational support, and preparation for independence.

Funding

TRY has a high level of fiscal diversity, with funding from state and federal grants, county and state per diems for residential services, third party insurers, private and corporate foundations, United Way, and private contributions. At TRY, each program is marketed and funded as a single service, and contracts are negotiated between TRY and the county, state, or federal funding source with separate program or unit costs for each type of service. During the period of January 1, 1988 to June 30, 1989, TRY's income included $2,808,112 (or 87 percent) from government support, $403,908 (or 12 percent) from The United Way, and $26,630 (1 percent) from various other sources.

Program Efficacy

The TRY program is evaluated by reviewing treatment plans at onset and assessing outcome at discharge. Externally conducted studies occur every four to five years. Successful outcome is determined by: developmental success criteria filled out at the onset of treatment, during treatment, and at discharge; progress in school; progress in the home or residential institution; employment; and feedback from youth.

TRY also has a follow-up system whereby discharged adolescents are tracked for at least a year, if not more. Many times, the youth maintain contact with the program through calls, writing, or coming back for meals. In these follow-up activities, TRY finds that many of the adolescents are doing quite well. The teen parent program has been exceptionally successful.

In the Loft Runaway and Homeless Youth Program, two- and six-month followups are conducted on all discharged adolescents. The results of this followup show that 94 percent of the adolescents remain at home during these two periods; 83 percent have not run away again; and 11 percent have moved into independent living, are at college, or are in another location approved by their parents. Only 6 percent have continued to run.

The Alternative Educational/Vocational Program (AEVP) has also been remarkably successful. Consistently, 75 to 80 percent of the youth complete the training, receive their GEDs, and are placed in jobs or enrolled in community colleges. These completion and placement

statistics are better than other local or statewide training programs for adolescents and adults that are not considered high risk.

Cultural Competence Principles

Acknowledgement of unique issues of bicultural/bilingual status

The TRY staff understand that poverty and minority status place many children and adolescents at risk. Minority children are particularly at risk for out-of-home and institutional placements. The literature indicates that they are more likely to be placed in restrictive settings than their white counterparts. TRY attempts to address this discriminatory pattern in the mental health and social services field by providing access to community-based services and programs for this population. Many of the TRY population, which is heavily African American, have had prior experiences and placements in the juvenile justice, child protective, and/or mental health systems. In order to improve access to community-based services for a population with oftentimes multiple out-of-home placements, TRY has a no-reject policy and, with few exceptions, will attempt to work with these youth in less restrictive settings.

It is characteristic of the TRY population to have learned to expect rejection by adults. These youth have developed defense mechanisms to hold others off, to protect themselves from forming attachments and the anticipated rejections and losses. In order to have a feeling of power instead of vulnerability, the youth attempt to control situations and to resist and defy rules set by adults. Within the TRY therapeutic environment, the adolescent has the opportunity to recognize and own feelings he or she was unable to resolve in relationships with early parental figures, and to learn more effective coping skills.

Family as the primary system of support and intervention

The TRY philosophy and treatment approach recognize the family as the primary system of support to the youth in treatment and the preferred point of intervention. At TRY, the goal of family work is to empower family members and create a positive change in the family system. Family work begins with assessment of the family's level of involvement, parenting capability, and/or the client's need and capacity to address family issues. Family members often need to learn how to talk and listen to one another about significant matters and to begin to relate more effectively as family. TRY recognizes that the definition of family can be extended to individuals who have assumed the role of family, including foster parents, shelter staff, or older siblings.

The family systems frame of reference is basic to treatment of troubled adolescents at TRY. An emphasis is placed on treating the whole family. TRY staff continue to try, no matter how hard, to preserve the family unit. The TRY family system perspective implies recognition of the following principles:

- The natural family is the most important formative influence in the child's development. The adolescent can only be understood in the context of his or her history in the family.

- The adolescent referred for treatment reflects not only his/her own, but also the family dynamics.

- There is a projection of these family dynamics on all other systems in which the adolescent is involved. The projections tend to create significant emotional impact on the treating system, and must be recognized and dealt with skillfully. During these projections, the adolescent will recreate, in a new living situation or group, the patterns of behavior learned from the family.

Working within a family systems perspective includes a commitment to reach out to the family and to assist it in becoming stronger and more capable. This may involve helping parents learn more effective ways of parenting while also giving honest messages to the adolescent regarding the parent's responsibility in the family breakdown. Outreach extends to other systems which have assumed, in the past, the role of the family with the client. As noted earlier, these might include former foster parents, shelter staff, and adult friends.

A family systems approach to the treatment of adolescents not only addresses what happens to the adolescent in treatment, but also addresses the staff who are often the recipients of the projections and demands of the adolescents. The staff tend to be pulled in the direction of mirroring and repeating the family dynamics; work with staff is required to assist the system in recognizing and disengaging from these patterns as they develop. The family systems approach also addresses necessary work at the boundaries between the adolescent group and staff group.

The involvement of the family may be challenging; TRY staff maintain that they never give up on the parents. Some units have parent groups and the day treatment program has a family outreach worker who makes contact with every home. Family treatment is ongoing, with family counseling conducted in the homes. Parents and staff are involved in problem resolution and parents *must* be involved in the treatment process.

Concept of responsive services

TRY started out as an agency primarily established for residential treatment. However, the ability of the administrators to keep in touch with the needs of the community have allowed the agency to expand and offer a variety of non-residential programs. Also, because of the responsiveness of the agency to community needs, it has expanded its services to include teenage parents and runaway and homeless youth. Services that are included in TRY's integrated service system are briefly described below.

Group Homes – TRY's concept of residential treatment is based upon a network of small group homes which stress the integration of youth into the community. The program is based upon individualized treatment planning, effective utilization of community resources, and the development of a family-like home environment with a range of specialized supportive services to meet the needs of troubled adolescents who need more supervision and treatment than is available at home or in other residential

care. Group homes rely on a multidisciplinary team approach. The program currently has a capacity to serve 16 youth.

Teen Parent Apartment Living Program – This program provides a wide range of services to the adolescent girl who has decided to raise her child and is preparing to move into independent living. There are four key goals of the program: independent living skill development, development of parenting skills, education/vocational development, and growth through individual counseling. This program has the capacity to serve four teen mothers and their babies in each location, or a total of eight teen parents and their babies.

Intensive Treatment Unit (ITU) – The staff-secure residential ITU is a highly structured short-term treatment setting for high-risk adolescents who have histories of multiproblem behaviors of a serious nature. Youth referred to the ITU need behavioral control and stabilization. ITU can be used for assessment, for residential treatment back-up, or it can be the first phase in a program of progressively less structured placement for adolescents with especially difficult social or behavioral problems. The program provides slots for 10 adolescents.

Apartment Living Program – This program assists older adolescent girls in preparing for independent living. The program provides the structure to assist youth in gaining the skills to function successfully in a semi-independent living environment and to prepare for living on their own. Youth considered for this program must be at least 15 years of age. These girls must have the ability to function without constant supervision and agree to work towards the mastery of skills leading to independence.

The Loft – This program is for runaway and homeless youth or for adolescents who are at immediate risk of running away from home. The program provides temporary shelter, crisis counseling, individual and family therapy, information and referral services, and a 24-hour hotline. The Loft has a four-bed shelter component which provides temporary residential care until a return home or move to an alternative residential setting is facilitated as well as a host family shelter which provides backup shelter as needed. Staff also provide family outreach, referral, and other supportive services. A drug and alcohol program is also available and sponsored under the Runaway and Homeless Youth Program.

Alternative Educational/Vocational Program (AEVP) – The AEVP prepares youths for success in the world of work, while helping them to complete a high school education. Program phases include educational and vocational assessment, job readiness counseling and preparation, remedial education, supervised on-the-job training, job placement, and intensive individual and group work toward adaptive behavioral and vocational goals. The program is aimed at reaching high-risk youth, who, for one reason or another, have had repeated failure in traditional classroom settings and/or have dropped out of school.

Day Treatment – This program serves high-risk youth who are at risk of separation from their homes, and is an alternative to residential care. It provides a structured afternoon and evening program of individual, group and activity therapy, as well as educational and vocational support to the young person while working intensively with the family. It operates seven days a week, with six days of structured program on a day and evening schedule, and individualized monitoring seven days per week. The program also provides outreach to families and involvement with community resources, 24-hour-a-day availability of professional staff, and temporary housing for a client in a family crisis situation. Transportation is arranged for the clients to and from the center.

Pathways - Services to Pregnant and Parenting Youth – Pathways is an information, support and referral service to help young parents and expectant parents, both males and females, in gaining access to the continuum of community support services so that they may successfully achieve relevant educational, employment, and training goals. The program includes a strong outreach component and utilizes supportive individual, group and family therapy. Case management is provided, as needed, to assist participants in negotiating access to services and, once access is gained, in becoming more self-sufficient and responsibly participating in such services. A program for GED instruction is also an integral part of services. Pathways also has a home-based program component which provides intensive counseling and support to young parents in their own homes.

Therapeutic Services – The TRY Youth Center for Therapeutic Services is a free-standing adolescent partial hospitalization program for high-risk youth or young adults in need of a highly structured and intensive day or afternoon/evening program. This program is a central service in the TRY integrated treatment system. Youth from each program have access to it as needed. These services are designed to prevent hospitalization or residential treatment while those youth already in a residential program or hospital may be able to return to their family, or move to independent living sooner with the support of these services.

Working with natural, informal support systems

The community, including the neighborhood, is acknowledged as part of the larger therapeutic setting. This approach is based upon the fact that in community-based treatment programs, the youth attend neighborhood and city schools and churches, participate in recreational activities and cultural events, use health care facilities, and hold jobs. A significant part of the youth treatment is assisting them in learning how to understand themselves in the context of the community, how to advocate for themselves, and to begin to see themselves as potentially able to influence the larger society.

TRY staff note that they use whatever works for their youth as natural helpers. An African physician was utilized as a houseparent because he could not practice medicine in this country. A priest assists with recreational activities, and the cultural experiences of an Indian Moslem staff person have made valuable contributions to TRY services.

Recognizing the importance of the community, TRY is making a more conscious attempt to involve community persons and organizations more closely with its programs. Staff are targeting, for these efforts, churches, schools, community groups, and agencies. For instance, just recently a Sunday school class of a local church "adopted" one of TRY's group homes. Over 50 members of the congregation decided to provide landscaping services to the site and to offer sewing and photography classes to the adolescents in the home. This proved very beneficial for community acceptance, as well as providing additional resources and attention for the adolescents. TRY would like to encourage more churches and social groups to adopt in a similar fashion.

Provision of an integrated network of services

One of the major strengths of TRY is its integrated service system approach. This means that an array of services, at varying levels of intensity, are offered within one agency. Individualized treatment plans are developed for each adolescent who can utilize many different TRY programs. Further, as the adolescent makes progress, he or she can be moved to another level without undue disruption and delay. If a client's treatment involves more than one TRY program, a primary case manager is assigned as defined by TRY's case management system.

TRY's links with other service providers are also numerous. Some identified by management include: the Pennsylvania Council of Children's Agencies, the Children's Council, the Children's Services Providers Association, and the National Runaway Network. As noted earlier, TRY also has referral agreements with several other child-serving agencies in Allegheny County. The agency maintains a relationship with the Western Psychiatric Institute and Clinic for the provision of psychiatric services. The agency also contracts out for alcohol and other drug services, rape crisis group services, and other specialized services needed by individual adolescents. Each of the TRY programs also maintains agreements and linkages with the various agencies responsible for funding, referrals, or provision of additional services to the identified population.

Staffing patterns and ethnic composition

Management determines the need for bicultural staff based on the current cultural and/or racial composition of clients. Prospective staff are reviewed under these circumstances based upon their environment, family background, cultural competency, or how well it is perceived that the new staff person will be able to work with a team that is culturally diverse. All interviews of potential staff are conducted by an ethnically mixed group. Once the staff person is selected, the emphasis is placed on helping that individual incorporate diversity and move beyond his or her own cultural values in providing treatment.

TRY employs a total of 79 full-time staff. There are 13 administrative staff of which 54 percent are African American. There are 59 treatment staff of which 66 percent are African American, and 7 support staff of which 42 percent are minority. Currently, the racial composition of the staff is: 46 African Americans, 30 Caucasians, 1 African, 1 Asian, and 1 Native American. Of the 79 staff members, 56 are female and 23 are male, with the average age being 35 years.

The staff consists of clinical treatment persons from the disciplines of social work, psychology, education, nursing, and art/recreation therapy. In addition, there are houseparents, child care workers, therapy aides, and other paraprofessionals. In addition to this staff, TRY contracts with consulting psychiatrists and psychologists for psychiatric evaluations, medication reviews, and assessments and testing, when needed.

Although it employs a mixed ethnic staff, key positions in the organization are held by African American professionals, thereby providing positive role models for many of these youth who have low self-esteem, low inspirations, and limited interaction with African Americans with authority and compassion. Although this is not necessarily a conscious goal of the agency, it is, nevertheless, a critical factor in the development of social and emotional skills for many of these youth. Establishing relationships are the key to behavioral changes and the perception that African Americans are there to assist and help them was mentioned by several of the youth interviewed. On the other hand, white parents also noted during an interview that the caring and commitment of the treatment staff (who were all African American) seemed to be the critical difference in a successful treatment outcome for their son who had experienced several unsuccessful prior placements.

Cultural competence training

TRY maintains a contract for the development and implementation of training activities in the agency. The contractor is a African American professional who is a former employee and has a substantive background in organizational development as well as versed in the use of cultural issues in therapy and management. Training is accomplished through contract services, competency-based supervision, team meetings, clinical case conferences, consultative processes, and use of a core training curriculum.

For the most part, cultural issues that arise are integrated into core training areas, such as family systems dynamics or therapeutic techniques. However, cultural issues are likely to surface in the assessment and treatment of clients and their families. Therefore, for the most part training in cultural competency issues is handled during staff supervision and skills building meetings. Staff retreats are also conducted and staff are often challenged to deal with anger and other reactions, some of which may be racially tinged. Also, supervisors and executives are always open to staff exploration of these issues.

The TRY executive director believes that although cultural competency training is important, it does little to change agency practices or attitudes unless it is incorporated into the very fabric of the daily operation. The training must be utilized at all levels: assessment, family interviews, therapy sessions, and education. Therefore, she believes that training in cultural competence can best be accomplished through the staff supervision structure.

Understanding the dynamics of difference

Since the staff and clients of TRY are of diverse ethnic backgrounds, there are always situations in which the dynamics of cross-cultural interactions have to be understood and

addressed. For example, because of its history and the fact that the current executive director as well as the majority of the clients in treatment are African Americans, TRY is frequently identified as a "black" agency, oftentimes with very negative connotations. Racial issues almost always arise when the agency attempts to purchase group homes in neighborhoods that are racially mixed or predominantly white. However, the agency has had remarkable success in locating its group homes in good neighborhoods throughout Allegheny County.

The dynamics of difference also arise when TRY staff interact with some of the other systems. Not surprisingly, TRY has the most difficulty with the court system. Many of the youth that are accepted or admitted to TRY have become involved with the courts. Since many of these children are African American and currently all of the judges and advocates are white, it is often difficult to convince them that a less restrictive setting may be appropriate. There is a tendency to place these youth in punitive and more restrictive settings rather than to recognize the need for more therapeutic community interventions. TRY staff have met with judges to describe their approach and program, and some progress has been made.

The dynamics of difference often present within the TRY programs as well. Given the large number of African American youth in TRY programs, during the intake interview, attitudes and beliefs about other racial groups are explored. This is especially critical for white and Latino/Hispanic youth who may be the only one of their ethnicity in a group home or other residential program. It is especially important to explore the feelings of white youth from rural communities who may not have had much exposure to other racial groups. The issue also arises when a group home has a majority of white youth and an African American or Latino/Hispanic youth is being considered for admission.

Minority participation at all organizational levels

TRY includes minorities at every level of the organizational structure. At least 50 percent of the current executive team is African American, as is the executive director of the agency. Two-thirds of the treatment staff are African American. Also, the consultant utilized for training is an African American professional.

There is also minority representation and participation on the board of directors, which is the governing body for the organization. Of the current 23 members, 9 are minority (40 percent). The current president of the board is an African American female.

Additionally, TRY adolescents also participate in the policy development process within the organization. There is a Youth Advisory Board which is chaired by the executive director. Two youths from each program make up the board which meets monthly. The board provides the opportunity for youth to air complaints, share ideas, receive recognition, and influence policy. Young people whose social skill development would not make them ideal candidates for leadership in other settings may be selected by their peers as members or officers of the Youth Advisory Board. More than half of the current members are African American adolescents. This board has proven to be beneficial to the development of higher levels of self-esteem among the youth.

U.S. PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE/YAKIMA SERVICE UNIT
MENTAL HEALTH/SOCIAL SERVICE PROGRAM
YAKIMA INDIAN RESERVATION*

Toppenish, Washington

It is significant that the Mental Health/Social Service Program on the Yakima Indian Reservation values working with natural, informal support and helping networks within Indian communities. This approach may range in scope from utilizing the services of a natural helper on the staff to utilizing the services of other elders/spiritual leaders on the reservation.

Brief History and Identification of Agency

The Mental Health/Social Service Program in the Indian Health Service (IHS) Yakima Service Unit is a component within the organizational structure of an outpatient health clinic. It is centrally located with easy access to other key services such as medical, nursing, nutrition, and maternal and child health.

This Mental Health/Social Service Program began in the 1960s when two social workers were hired to serve as outreach workers for neglected and abused children and their families on the Yakima Reservation. The program later expanded to include paraprofessional counseling and coordination with other child-serving agencies. A Community Mental Health Center grant was subsequently awarded to the local community mental health unit which, in turn, subcontracted with the Yakima Indian Nation (YIN) for a full complement of community mental health services. That grant expired approximately six years ago. Since that time, the Mental Health/Social Service Program on the Yakima Indian Reservation has been provided by the IHS, an agency of the U.S. Public Health Service.

Consistent with one of the four types of agencies described in Volume One of the *Towards A Culturally Competent System of Care* monograph, the Mental Health/Social Service Program is seen as a mainstream agency which supports services by minorities within a minority community. Indeed, the concept of noninterference for this federally funded program is an important element

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*In reviewing this program description, comments and input were solicited from the program staff, the Indian Health Service (IHS), and Tribal Council members. Some of these comments have been incorporated into this document. However, it should be clearly stated that the opinions expressed in this program description are those of the authors and do not necessarily reflect the views of the IHS or the Tribal Council. Although the IHS headquarters is located in Rockville, Maryland, the IHS is divided administratively into 11 area offices. Each area office is responsible for operating the IHS programs within a designated geographic area. The Portland Area Office of the IHS encompasses the states of Washington, Oregon, and Idaho. Delivery of health services at the local level is the responsibility of an IHS service unit (an administrative subdivision of an area) and, as such, it is the Yakima Service Unit which has responsibility for this Mental Health/Social Service Program.

of this service delivery model. In fact, although the IHS establishes program policies, allocates funds, provides technical assistance, and monitors and reviews programs, it is through P.L. 93-638, the Indian Self-Determination and Education Assistance Act of 1975, that the YIN has the opportunity to exercise self-determination. This is accomplished through the design and implementation of programs which are responsive to the traditional and cultural teachings of the Yakima people. It is felt that the YIN is in the best position to identify the needs of its people and to determine how these needs can best be met.

The Mental Health/Social Service Program of the IHS is located within a 40,000 square foot ambulatory care clinic on the Yakima Reservation. The Yakima Service Unit is responsible for the direct delivery of health services at the community level to the members of the YIN as well as to members of other tribes who are currently residing on the reservation.

Community Description

The Yakima Indian Reservation lies in the south central portion of the State of Washington. It is bounded on the west by Mt. Adams and the crest of the Cascade Mountains and on the east by the Yakima River. The reservation contains 1.4 million acres of prime agricultural, forested, and range lands. Tribal headquarters is located in the city of Toppenish in the eastern area of the reservation. Toppenish is 19 miles south of Yakima and within a 200-mile radius of Spokane, Seattle, and Portland.

Although the reservation encompasses 1.4 million acres, 80 percent of this land is held in trust to the United States for the benefit of the YIN and/or its individual members. The remaining acres are held in fee status by individual tribal members and by a few non-Indians. There is a "closed" area of the reservation which contains a portion of land which is the natural habitat for wildlife. Access to the closed area is limited to YIN members and non-members receiving written permits.

The YIN suffers extreme community disruption, destruction, and death due to alcohol and substance abuse. Problems resulting from these abuses are extreme; the effects are long lasting and not easily corrected. Public attention has been focused on the tragedies caused by alcohol abuse since the IHS declared such abuse the number one health problem among American Indian and Alaska Natives.

Significantly, there is a Yakima Nation Cultural Center located on the reservation near the site of the IHS Clinic. It is a beautiful modern complex with a skillful architectural design, reflecting Yakima Indian art, culture, and tradition.

Target Population

The registered service population at the Yakima Service Unit clinic is more than 13 thousand, including thousands of Indians who are from other tribes. Approximately 51 percent of the service population is female and 49 percent male. The largest single age group is the 15

to 19 year olds. They represent 12.4 percent of the client population. A full 46 percent of the service area population is under the age of 20.

The median age of the Indian population nationwide according to 1980 census data was approximately 23 years compared to 30 years for the U.S. population as a whole (Trends in Indian Health, 1990 Indian Health Service). A high birth rate and high death rate, a large population of child-bearing age, a high rate of unemployment (80 percent), a high poverty incidence, reduced federal spending for human service programs, and low median income for American Indians all contribute to economic stress on reservations. Thus, it is not surprising that American Indians are among the most impoverished groups in the United States. Individuals and families often live without adequate nutrition, shelter, and other basic services.

The population of children targeted for services on the Yakima Indian Reservation include dependent and neglected children, those presenting school problems, and children diagnosed as having depression, adjustment reaction, conduct disorders, developmental delays, fetal alcohol syndrome, and drug and alcohol problems. The age range of children and youth served in the program is from 4 to 24 years. Although virtually no children were seen in the clinic's mental health program two-and-a-half-years ago, at least 200 children and their families have since received appropriate services. The current number of children being seen in the program is 110.

Program Philosophy and Goals

The mission of the IHS Mental Health/Social Service Program is to promote, provide, and manage a system of mental health services which offer American Indians a range of culturally sensitive services for all types of mental health needs. The treatment philosophy adheres to the principle of letting families define problems themselves and not being too "intrusive" with interventions. Assistance to clients/families in defining their goals is provided and brief treatment is valued. There is a policy of giving preference to hiring Indian staff. Thus, shared cultural values eliminate the struggles of cross-cultural interactions in the program. Cultural knowledge is employed in a cooperative or integrative manner with Western attitudes and practices as is consistent with the unique belief systems of the American Indian families. Strengthening families is a major goal and, as such, programs are designed to help families to function in healthier ways.

Services

In addition to mental health, other services provided by the Yakima Service Unit include medical, dental, pharmacy, sanitation, laboratory/X-ray, public health nursing, and environmental health. Maternal and Child Health, Women and Infant Care, Nutrition, and Home Health are all tribal programs administered by the YIN via contracts with IHS. Since all of these services are located at the clinic, clients are able to take care of most of their physical and mental health needs in one location and the stigma of receiving mental health services is greatly reduced. In addition to regular outpatient mental health services for children and adolescents, specific programs offered to children and adolescents include: (1) a substance abuse program for American Indian youth, (2) a group treatment program for pre-adolescent American Indian girls who have been sexually abused, and (3) child protection team services. The Youth Substance

Abuse program offers assessment, treatment planning (outpatient counseling or arrangement for inpatient admissions to IHS facilities or other treatment programs), aftercare counseling, and group treatment (like Alateen). An aftercare substance abuse group is held in one of the Alternative Schools on the reservation.

Funding

The total Yakima Service Unit operating budget for FY 1990 was $2,433,384, of which $79,300 was a mental health budget line item. The balance of the mental health budget is funded through the clinic budget. All funding is provided through the federal government with some Medicaid revenue being generated. Although federal funding has been stable, it is inadequate and, thus, the program is able to serve only a small number of people. It is expected that the budget will increase substantially in the next year in connection with a move to a new facility; new programs are anticipated. Clients are not charged fees for services.

Program Efficacy

The Mental Health Social Service Program is reviewed annually by the Portland Area Office Mental Health Specialists. As a Joint Commission on Accreditation of Hospitals-accredited medical clinic, monthly quality assurance meetings are held. Additionally, peer reviews are held on a regular basis and quarterly patient satisfaction surveys are done for all clinic services. The mental health program is responsible for developing a systematic, integrative approach to the care of children and families of children with mental health problems. Program evaluation standards have been established in the following areas: individual evaluations, treatment planning, followup, and discharge and documentation.

It appears that the Mental Health/Social Service Program provides effective services to Indian children, adolescents, and their families and is supportive of the concerns and needs of clients. Indicators of success include reduced absenteeism at school, positive behavioral changes, decreased abuse of alcohol and other substances, and improved family functioning.

Cultural Competence Principles

Acknowledgement of unique issues of bicultural/bilingual status

Cultural competence principles are utilized in a number of ways by the Mental Health/Social Service Program. For example, by utilizing a group treatment approach for preadolescent American Indian girls, the program has been able to address some of the unique difficulties which minority populations experience in utilizing the mental health system due to their bicultural/bilingual status. This group approach was designed to increase access to and acceptability of services to victims of child abuse and neglect and to respond to the mental health needs of these girls within the context of their culture. As an alternative to treatment models which are designed for families and children of the dominant Anglo culture, this model was designed to be sensitive to American Indian culture and to help American Indian children who are victims of sexual abuse to reintegrate their experiences into a healthier level of functioning

in their community. Traditional values and norms of behavior are reinforced by the program to give American Indian children a new concept of boundaries which have been violated by the abuser. This group treatment model takes into consideration the developmental, physical, emotional, and spiritual needs of preadolescent American Indian girls. It is simply a return to a traditional holistic approach to healing which focuses on the whole person rather than on symptoms of pathology. This holistic approach to health is one which is shared by all American Indian cultures and can be adapted along a cultural continuum ranging from traditional to bicultural and assimilated lifestyles.

Two cotherapists who are female mental health professionals facilitate the group process for this program. Activities vary to include a "Talking Circle" (referenced in Volume One of the monograph), a physical activity, and a brief presentation by women from the Indian and non-Indian communities who share information about a range of topics. These topics include traditional home life in healthy family systems, the legal system and prosecution of offenders, substance abuse, and issues related to children of alcoholics. Other topics include medical and ancillary health problems, ego enhancement, self-esteem building, and problem solving to prevent further abuse. Each session ends with a nutritious snack.

Another mechanism which the program uses to increase access and acceptability of mental health services is a preference for hiring Indian staff. Six of the seven members of the staff are American Indian, four of whom are enrolled members of the Yakima Tribe. One of the staff positions is that of a paraprofessional counselor who is fluent in the Yakima language, has visited the "old households" on the reservation, and participates in case conferences because of her knowledge of Indian culture and her relationship with the Indian community. Practices such as these assure that language and cultural barriers are not impediments to effective service delivery.

Family as the primary system of support and intervention

Family is defined broadly and may include adult siblings of parents, grandparents, or other adults with whom the child relates. Families tend to share material resources as well as responsibilities for childcare. They are expected to participate in the nurturance and protection of Indian children. There is an attempt to help children bond with extended family members and this bonding may be to multiple parent and grandparent figures. This has often been misinterpreted by non-Indians as dysfunctional because it often does not follow the dominant culture's expectation of what constitutes appropriate family care. Approximately 80 percent of the Indian children on the Yakima Reservation are from intact, supportive families, and approximately 20 percent are in foster or other non-biological families.

Contact is maintained with the child's family depending upon where the family is located. If the family is located near another reservation, then the program on that reservation usually maintains contact with the family.

The program's philosophy is one of letting the families define the "problems" and a respect for the families right to "distance." For example, there was a case involving two Yakima boys ages 8 and 11 who had been raised by grandparents and aunts since infancy and who were anxious

about having to have court-ordered visits with their mother who had not been involved with them for many years. A non-Indian counselor from another community mental health agency went to see the boys at school and this heightened the boys' anxiety. The case was referred to one of the staff members of the Mental Health/Social Service Program who was a close friend of the grandmother. The staff person was invited to a family dinner to meet the boys and let them know she'd be there to help them with their apprehensions about their mother and possible separation issues concerning the relatives who had been caring for them since infancy. By approaching the issues from a family perspective and at a family dinner, the Mental Health/Social Service Program was able to begin to address the principle of the family as the primary system of support and preferred point of intervention for agency services.

Importance of cultural assessments

The program places considerable emphasis on assessing the level of acculturation and assimilation of individuals/families in order to provide appropriate services. This is exemplified by staffing patterns which assure that the program has the capacity to make such culturally competent assessments (via Indian preference for hiring staff) in the agency data gathering procedures which includes documenting in case records information on cultural ties, as well as information on the cultural and spiritual history of the client population. For example, in the treatment services planning guide, questions are asked about the client's feelings about being an American Indian and what the client is doing to preserve his/her Indian identity that makes him/her feel good. Cultural assessments are done along a continuum to determine the client's needs within the belief system. For example, child-rearing practices are reviewed and questions are asked to determine the degree of traditional practices such as whether one uses Indian doctors, what types of social activities are preferred, whether native language is spoken, and the degree to which one associates with only Indian people.

In interviewing children and adolescents during the intake process, an attempt is made to evaluate cultural ties. For example, information is gathered regarding whether the child participates in dancing or drumming at pow-wows, is involved in other traditional celebrations, has an Indian name, and/or attends traditional Indian gatherings or other events. Also, in completing a detailed history for clients in the alcoholism treatment program, a cultural and spiritual history is taken. This includes obtaining information as to whether the person was raised in an Indian community or the extent to which he or she participates in Indian cultural, religious, or spiritual activities. Obviously, this reservation-based program places considerable emphasis on Indian culture and is dedicated to providing high quality services that protect, maintain, and enhance the traditional Yakima culture and values while also providing clients with the necessary skills and knowledge for living in an ever-changing world.

Working with natural, informal support systems

The program places a great deal of value on working with natural, informal support and helping networks within Indian communities. These practices range in scope from utilizing the services of a natural helper on the staff to utilizing the services of other elders/spiritual leaders on the reservation. Most of the staff are visible as members of the reservation community and

interact with the community in a number of spiritual, social, and recreational activities which help them to be seen as "natural helpers" by the community. Clients are encouraged to work on their spiritual paths and are taught cultural ways of keeping themselves strong and healthy. Through such practices as encouraging clients to participate in "Sweat Lodges" and through taking children and youth on outings in the closed area of the reservation, the program works effectively with natural support and helping networks. The Sweat Lodge tradition varies from tribe to tribe, but essentially it is a holistic cleansing tradition for people to strengthen themselves physically, emotionally, and spiritually. An elder in the family usually helps young people learn about the ceremony and facilitates the prayer offerings.

Provision of an integrated network of services

Because the program is located in a rural, close-knit reservation community with limited resources, interagency coordination is essential. Ongoing communication occurs with all agency referral sources and feedback is constantly received via interagency child and adolescent case conferences. Moreover, the program is located in close proximity to the governing body of the Confederated Tribes and Bands of the Yakima Indian Nation and the programs/services of the Tribal Governmental departments (Natural Resources, Human Resources, Law and Justice, and Support Services) are just a few steps away from the mental health program. This means that there is accessibility to Tribal services and personnel, and thus, communication takes place with relative ease. Indeed, during the site visit interviews were held with high Tribal governmental officials, including the chairman of the Yakima Indian Nation General Council, several members of the executive board of the Yakima Tribal Council, including a member of the Health, Employment, Welfare, Recreational Youth Activities Committee and the Children's Court Judge of the Tribal Children's Court. According to the Children's Court Judge, 80 percent of the cases that come before his court have to do with child abuse and neglect. This means that he works closely with the mental health program so as to assure that evaluation and treatment services are provided to children and families. The coordination between the Tribal Children's Court system, the state child welfare system, and the mental health program appears to be working well at least in abuse and neglect cases.

The local Indian Child Welfare Committee represents an excellent example of interagency coordination. This team serves as an advisory committee in Indian child abuse and neglect situations for the state Child Protective Services Division. Cases of child abuse and neglect are monitored and tracked.

As the IHS and the Bureau of Indian Affairs move more into the Indian Child Welfare arena, it is felt that model programs which are culturally congruent and which demonstrate a range of preventive, remedial, and intervention services need to be developed in order to strengthen Indian families. Currently, there are gaps in services such as the need for a Native American child protection case manager to coordinate services.

Many referrals are received from the schools. Requests for service are for any number of emotional problems as well as for assessment or intervention for substance abuse problems.

Staffing patterns and ethnic composition

There are seven staff positions assigned to the Mental Health/Social Service Program, three are at the master of social work level. There are two BA-level substance abuse counselors, one social work associate, and one secretary. There is also a part-time consultant/psychiatrist position. As noted earlier, six members of the staff are American Indian, four of whom are members of the Yakima Tribe. Whenever possible, American Indians who live in the community and are acquainted with clients/families are employed as staff. Strict job qualifications are set by the Portland Area Office of the IHS regarding the training, background, and experience of staff. Additionally, attention is given to successful work experience with Indian people. A capacity to relate to Indian people and to "roll with the punches" is seen as an important ability for staff positions.

The staffing patterns are, of course, reflective of the makeup of the client population. One hundred percent of the administrative and support staff is American Indian and 80 percent of the treatment staff is American Indian. Staff turnover is rare. The only turnover experienced in the past two years was when the former mental health director was promoted to the position of Yakima service unit director and the former secretary was promoted to the position of supply coordinator. Whenever there are vacant positions, they are easy to fill. Vacant positions are advertised within the department locally and regionally.

Cultural competence training

The staff participate in cross-cultural exchanges where Indian staff from Yakima and other tribal backgrounds share similar and different aspects of their culture with non-Indian staff. These sessions range from informal brown bag lunches to formal presentations. Specific exercises are designed to help the non-Indian staff identify their early recollections about ethnicity, racial differences, and family and community values with regard to cultural, racial, and linguistic differences, symbols of their culture, and traditional dress. Cross-cultural training for staff of the entire health center is held occasionally. Training activities are coordinated by a specific staff person. Staff participate in four training sessions a year. Training content includes cross-cultural issues and is presented in a non-threatening way. Training on Indian culture is provided to mainstream agencies as indicated.

Minority participation at all organizational levels

Minority participation in planning, governing, and administering the development and implementation of services is apparent in this community. Although program policies are established by the IHS, there is a close working relationship between the YIN's Tribal Council and the IHS. In fact, it was the consulting psychiatrists from the IHS in Portland who nominated this program as one that provides culturally competent services for minority children and adolescents who are severely emotionally disturbed.

The executive board of the Yakima Tribal Council has the authority to approve agreements and contracts on behalf of the Confederated Tribes and Bands of the YIN. There is a very high level of minority participation in planning, governing, administering, and implementing services. In addition, the board shows a very high regard for treaty provisions, laws, cultural and spiritual traditions and practices, culturally specific program development and implementation, and cultural knowledge.

The Yakima Tribal Council approves all Tribal programs, services, and budgets according to established policies and procedures. The deputy director of the Department of Human Services and the committees that work with program managers/coordinators have the initial responsibility for human service program development. The benefit to the Yakima Indian people is that the Department of Human Services centralizes under one administrative umbrella all of the services that affect the quality of life of the Yakima Indians. This allows comprehensive planning for service delivery while ensuring that funds are spent in the most cost effective manner.

Support of self-determination for the broader minority community

Federal legislation such as P.L. 93-638, the Indian Self-Determination and Education Assistance Act of 1975, has influenced the mental health program for American Indians. As previously stated, this law provides the YIN with the opportunity to exercise self-determination by designing and implementing programs that are sensitive and responsive to the traditional and cultural teachings of the Yakima people.

Tribal government is represented by 14 council members elected by the General Council which is composed of enrolled members of the Yakima Tribe over 18 years of age. A chairman serves as chief executive officer of the Tribal Council. In addition to the chairman, the executive board of the Yakima Tribal Council also consists of a vice chairman, a secretary, and an eight-member standing committee. Each member of the executive board has the authority to approve agreements and contracts and to sign all other pertinent documents on behalf of the Yakima Tribal Council. The Yakima Service Unit of the IHS which reports to the Deputy Director of Human Services of the YIN is, as stated earlier, responsible for the direct delivery of health and mental health services at the community level. In addition to services already outlined in this program description, other activities provided include participating in informational meetings with various groups in the community such as school counselors, school nurses, non-Indian therapists working in the community, and Indian parent groups from various school districts as well as Head Start staff on the reservation. All of these activities impact on issues affecting the larger minority community on the Yakima Indian Reservation.

APPENDIX I

Nomination Form

Screening Survey Form

NOMINATION FORM

CULTURALLY COMPETENT PROGRAMS FOR MINORITY CHILDREN AND ADOLESCENTS WHO ARE SEVERELY EMOTIONALLY DISTURBED

Respondent Name _____ Title _____

Address _____ Telephone _____

Nominated Program/Agency: _____

Address: _____

Telephone Number: _____

Contact Person/Position: _____

Community Served: ____Urban ____Rural ____Suburban

Type of Agency ____Public ____Private, non-profit ____Private, profit ____Other

____State ____County ____Local

Percentage of children served in the following racial/ethnic groups: ____Hispanic/Latino ____Black/African American ____Asian/Pacific Islander ____Native American/American Indian ____White/Caucasian

Age range of children served_____

Types of Services provided:

____Case Management
____Outreach
____Respite Care
____Psychoeducational/Day Treatment
____Emergency/Crisis Program
____Therapeutic Foster Care
____Therapeutic Group Home
____Outpatient Services
____Inpatient Services
____Residential Treatment Center
____Other (please describe)

Reason for nominating program: (check as many as apply)

____Outstanding policymaking ability
____Exemplary administrative practices
____Outstanding clinical practices
____High degree of consumer satisfaction
____Other (please explain)

Check the principles of a culturally competent system of care utilized by the nominated agency:

____ The family, as defined by each culture, is the primary system of support and point of intervention.
____ Minority populations are at least bicultural and often bilingual, creating a unique set of systems issues.
____ The level of acculturation and assimilation of individuals/families must be assessed in order to provide appropriate services.
____ Cultural knowledge must be included in practice and policymaking.
____ Cultural competence includes working with natural, informal support and helping networks within minority communities.
____ Minority participation is essential in planning, governing, administering and evaluating the development and implementation of services.
____ Staffing patterns must reflect the makeup of the client population to insure the delivery of effective services.
____ Culturally competent services include the concept of responsive services matched to the client population.

PLEASE FOLD THIS FORM SO THAT PREPRINTED RETURN ADDRESS (ON BACK) IS SHOWING, STAPLE IT CLOSED, AND MAIL IT BACK SO IT REACHES US BY OCTOBER 25, 1989 (DEADLINE FOR SUBMISSION)

Thank you for your assistance!

SCREENING SURVEY

CULTURALLY COMPETENT AGENCY/PROGRAM FOR MINORITY CHILDREN AND ADOLESCENTS WHO ARE SEVERELY EMOTIONALLY DISTURBED

Identifying Information

Name of Program _____

_____

Name of Agency (if different)_____

Address _____

_____

_____

Telephone _____

Type of Agency: _____ Administrative _____ Direct Service

If Administrative, check those that apply:

_____ Planning
_____ Oversight
_____ Policymaking
_____ Program Development
_____ Evaluation

If Direct Service, check type of services provided:

_____ Case Management
_____ Respite Care
_____ Emergency/Crisis Program
_____ Therapeutic Group Home
_____ Inpatient Services
_____ Other (please describe)
_____ Outreach
_____ Psychoeducational/Day Treatment
_____ Therapeutic Foster Care
_____ Outpatient Services
_____ Residential Treatment Center

Name of Contact Person(s)

Name _____ Name _____
Title _____ Title _____
Phone _____ Phone _____

Program Characteristics

1. In what year was your program established? _____

2. What kind of community does your program serve?

Urban _____ Suburban _____
Rural _____

3. Which of the following describes your agency? (Check all that apply)

Public	_____	State	_____
Private not-for-profit	_____	County	_____
Private for-profit	_____	Local	_____
Other:	_____		

4. (a) List the funding sources for your program. Please indicate the approximate percentage of your budget each funding source represents.

Funding Source	Estimated Budget
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(b) Do clients pay a fee for service? Is there a sliding scale?

5. What are the three major sources of client referrals to your program? Please list in rank order.

1. _____
2. _____
3. _____

* For the following questions, if agency has more than one program, use additional forms.

6. What is your program's capacity? (i.e., how many children can be served at any one point in time?)

_____ children _____ families

7. Is there a waiting list for your program? Yes_____ No _____
Duration of waiting period _____

8. What is the age range of the children served in your program?
_____ years to _____years

9. What percentage of the population in your program is male, female?

Male:_____percent Female:_____percent

10. Indicate the percentage of children you serve in each racial group listed below:

	Percent
Black/African American	_____
Hispanic/Latino	_____
Asian/Pacific Islander	_____
Native American/American Indian	_____
White/Caucasian	_____

11. What is the composition of your current staff?

Number of Administrative	_____	% Minority_____
Number of Treatment staff	_____	% Minority_____
Number of Support staff	_____	% Minority_____

Males_____ Females_____
Average Age_____ Professional_____ Paraprofessional_____

Racial composition

Number of White_____ Number of Black_____
Number of Hispanic_____ Number of Native American_____
Number of Asian_____ Other_____

12. What percent of staff have left during the last year?

13. (a) What is the composition of your Board of Directors?

_____ How many
_____ Number of minorities
_____ Male
_____ Female

(b) What is the composition of your agency's advisory group (if any)?

_____ How many
_____ Number of minorities
_____ Male
_____ Female

14. What strategies do you use to tailor services to different cultural/racial groups?

_____
_____
_____
_____

15. Please describe your treatment philosophy and how it relates to the clients you serve.

16. Please provide an example of a typical case and intervention strategy.

17. What are the major cultural factors used to determine the types of interventions provided?

18. Please describe your physical plant and location.

19. What are some of the unique attributes of your facility that make your clients comfortable within their environment? (Please emphasize culturally unique aspects of the program.)

20. What qualities/characteristics do you look for in selecting staff?

21. Do you evaluate your staff for cultural sensitivity and competency? If so, how?

22. As part of your assessment process, are you able to determine the degree of your clients' acculturation/assimilation? If so, how? If not, why not?

23. Do you provide any specialized culturally focused preservice and inservice training for your staff? Which staff? What types of training? Please describe (please ask about length of training/content).

24. Do you use nontraditional helpers to support or deliver services in your program? If so, which ones and how are they utilized?

25. Does your agency have other activities or policies that are designed to be supportive of clients/individuals from different cultural groups?

26. Describe how you link with other service providers in the community.

27. Describe follow-up procedures with your clients.

28. Describe any community based network activities.

29. Check which characteristics best describe your agency/program:

(a) Agency/program providing direct services to minorities. _____
(b) Agency supporting service program provided by minority professionals and/or natural helpers in a minority community _____
(c) Agency providing direct bilingual/bicultural services _____
(d) Minority agency providing services to minority people _____

30. (a) How do you evaluate your program?

(b) What indicators are used to determine success?

Thanks for your assistance.

APPENDIX II

Profiles of Programs/Agencies Utilizing
Culturally Competent Principles

Table 1 - Agency Profiles

Table 2 - Programs by State and Racial Group Served

PROFILES OF PROGRAMS/AGENCIES UTILIZING CULTURALLY COMPETENT PRINCIPLES

The profiles which follow are of a variety of programs that have adapted some aspect(s) of their service delivery program to the needs of children of color, their families and communities within the context of their culture. These programs, which were identified through a nationwide survey, span every region of the country. Subsequently, they participated in an extensive structured telephone interview process (See Appendix I for screening survey instrument utilized). The information in these profiles was obtained via this process.

Although 98 programs participated in the survey, only 11 of these programs were selected for site visits. Program descriptions for these 11 programs can be found in Chapter Four of the monograph. Fifteen of the programs which participated in the extensive telephone interview process are not included in this monograph, because either they served adults only, didn't complete the interview process, or several programs of a particular agency were combined into one agency profile.

The process which led to the identification of programs described in the following tables involved forwarding a survey instrument to each identified program in preparation for the telephone interview. Detailed information about each program's characteristics and culturally competent activities was obtained. Subsequently, profiles were developed which included the following information:

- Name and location of program or agency.
- Agency Type refers to one of the four service delivery models described in Volume One. Whether programs were public, private-non-profit, or private-for-profit is also noted. Programs were assigned to a specific agency type based upon the dominant characteristics as determined by the authors of this monograph.
- Population Served refers to the racial identity of the group(s) served by a specific program or by the agency as a whole. The population groups served are identified as either African American, Latino/Hispanic, Native American, Asian/Pacific Islander, or Caucasian.
- Services Provided refers to the range of services provided as described by the agency's respondent.
- Age Range/Capacity refers to the range in age of children and adolescents served and the number of children and families served at a given point in time, unless otherwise indicated.
- Staff refers to the overall number of staff available and the percentage of total staff that are minority group members.

- Cultural Competence Training refers to the training on cultural competence issues provided directly by the program and/or encouraged or actively supported by the program.

- Treatment Philosophy refers to the philosophy of treatment as described by respondent and how such a philosophy relates to the clients served.

- Cultural Competence Strategies refers to the culturally specific activities undertaken in the program to improve services to the target population within the context of their culture.

The purpose of these profiles is to provide brief summaries of pertinent information on 72 of the programs which responded to a nationwide survey. It is important to realize that the programs which are summarized were developed in response to the needs of a particular population and the unique circumstances found in a particular community. Because of the vast differences in the numbers of staff assigned to the various programs, the varying numbers of clients served, the wide geographical distribution of the programs, and the variety of racial groups served, it is difficult to generalize from the data contained in these agency profiles. However, it is felt that much can be learned by carefully reviewing the information contained in the agency profiles on the cultural competence training provided, treatment philosophy of the programs, and the cultural competence strategies utilized by the programs. By doing so, the reader is provided a wealth of information about how cultural competence principles/values are exemplified by these programs. It is felt that such information will prove helpful to those who are interested in meeting the challenge of effectively serving children of color and their families.

It must be noted that certain categories of information, such as population served, age/capacity, and numbers of staff, may not be comparable across programs since some agency profiles represent an entire agency whereas other agency profiles represent only those programs within a particular agency which serve a substantial number of minority clients and have some focus on adapting services to meet the culturally defined needs of the population. In some instances, two or more programs were combined into a single agency profile that may or may not represent all of the programs provided by a particular agency.

In addition to the summary data contained in Table 1, further analysis of the data may be found in Table 2 which includes programs by state and a breakdown of the percentage of the population served by ethnic minority group into three percentage groupings (under 10 percent, 10 to 50 percent, and over 50 percent).

Finally, it should be stressed again that these programs do not represent the universe of programs which exemplify principles of cultural competence since there are many more programs across the country that have been successful in adapting their services to meet the needs of people of color within a cultural context. For a list of the addresses and telephone numbers of the programs contained in this monograph, see Appendix III.

TABLE 1

AGENCY PROFILES

Bertha Abess Children's Center
Day Treatment Program
Miami, Florida

Private, non-profit agency providing bilingual/bicultural services

Services Provided: Case management; outreach; outpatient; emergency/crisis; day treatment

Ages Served: 3-21 years

Capacity: 500 children/500 families (260 day treatment)

Total Staff: 101 (40% minority)

Population Served: 47% Caucasian; 28% African American; 25% Latino/Hispanic

Cultural Competence Training:

- Culturally oriented workshops periodically for 45 minutes to an hour during case conference time; content may include Latino/Hispanic families and traditions, etc.

Treatment Philosophy:

- Multidisciplinary approach
- Positive reinforcement
- Individualized
- Behavioral based
- Ongoing assessments

Cultural Competence Strategies:

- Programs in schoof to reduce stigma
- Multicultural staff
- Participate in cultural events such as Spanish Heritage Festivals; Black History Month
- Bilingual parent education
- Use of interpreters
- Use of non-traditional helpers

Atlanta Network Family Center
Refugee Resettlement Programs
Families in Transition
Atlanta, Georgia

Private, for-profit agency providing bilingual/bicultural services

Services Provided: Outpatient services; professional training (therapists and bilingual translators)

Ages Served: 0-21 years

Capacity: 40-50 families/150 children

Total Staff: 16 (12% minority)

Population Served: 60% Asian/Pacific Islanders; 30% African American; 10% Caucasian

Cultural Competence Training:

- Two-thirds of activities are culturally focused training
- Provide training for bilingual interpreters
- Understanding therapy issues in different cultures

Treatment Philosophy:

- Family systems model
- Recognize the impact of transitional issues on adjustment

Cultural Competence Strategies:

- Brochures and magazines dealing with cultural issues are available
- Genograms
- Use of bilingual workers
- Focus on family in the culture
- Focus on resettlement and transition issues
- Accessible location
- Respect sexual roles

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AGENCY PROFILES

Blue Ridge Area MH/MR/SA
Child & Family Services Program
Ashville, North Carolina

Mainstream public agency providing outreach services

Services Provided: Outreach; case management; respite; day treatment; emergency/crisis; therapeutic group home; outpatient services; family preservation; foster care

Ages Served: 0-18 years

Capacity: 100 families/300 children

Total Staff: 52 (13% minority)

Population Served: 79% Caucasian; 20% African American; 1% Native American; (3 satellite clinics in Appalachia)

Cultural Competence Training:

- Encourage staff to seek out training on cultural issues
- Annual pre-service training in day treatment programs

Treatment Philosophy:

- Each child/family is unique
- Family preservation
- Interagency interventions

Cultural Competence Strategies:

- Create treatment plans/consultations within the family's cultural perspective
- Low profile in community
- Community-based interventions

Sasha Bruce Youthwork, Inc.
Washington, D.C.

Private, non-profit minority agency providing services to minority people

Services Provided: Case management; outpatient services; emergency/crisis; group home; outreach; emergency shelter; foster care

Ages Served: 9-18 years

Capacity: 260 families/260 children (1,000 youth a year)

Total Staff: 70 (73% minority)

Population Served: 96% African American; 2% Caucasian; 1% Latino/Hispanic; 1% Asian/Pacific Islanders

Cultural Competence Training:

- Weekly inservice training is sometimes culturally focused
- Use consultants from D.C. community on such subjects as the Afrocentric approach
- Developed curriculum which can be used with clients
- Series of presentations about black historians

Treatment Philosophy:

- Family and youth empowerment
- Competency based therapeutic model
- Comprehensive assessment
- Respect for cultural differences

Cultural Competence Strategies:

- Art reflecting black culture
- Extensive use of community volunteers such as Big Brothers or Big Sisters
- Accessible location
- Family focused

Cambridge Hospital
Haitian Mental Health Unit
Cambridge, Massachusetts

Public agency providing bilingual/bicultural services

Services Provided: Emergency/crisis; case management; outpatient services; outreach

Ages Served: 4-19 years

Capacity: 22 families/54 children

Total Staff: 13 (38% minority)

Population Served: 100% Haitian

Cultural Competence Training:

- Inservices for all staff
- Clinic library with reading list
- Guests at inservices include anthropologists, writers, and healers

Treatment Philosophy:

- Empower the Haitian immigrant population
- Extended family involved in treatment
- Respect traditional Haitian values

Cultural Competence Strategies:

- Present ideas in ways that are culturally syntonic; storytelling reference to proverbs, etc.
- Act as cultural bridges
- Respectful of client's explanation of illness
- Work in conjunction with traditional healing modes, i.e., prayer as relaxation technique
- Psychological testing performed in French, Creole, and English
- Educate clients about expectation in their new environment
- Therapy offered in Haitian, Creole, French and English
- Testing instruments adapted to clients
- Focus on issues of acculturation

Central Community Health Board
Children's Services
Cincinnati, Ohio

Private, non-profit mainstream agency providing outreach services

Services Provided: Outreach; day treatment; outpatient services

Ages Served: 1-18 years

Capacity: 300 families/300 children

Total Staff: 14 (93% minority)

Population Served: 95% African American; 5% Caucasian

Cultural Competence Training:

- Workshops

Treatment Philosophy:

- No reject policy
- Consider environmental stress created by poverty, racism, etc.

Cultural Competence Strategies:

- Use of natural support system (minister and family doctor)
- Deliver services in schools or homes
- Flexible scheduling
- Culturally relevant pictures and toys
- Outreach

AGENCY PROFILES

Children's Hospital
School-Based Mental Health Program
Multicultural Services
Washington, D.C.

Private, non-profit agency providing bicultural/bilingual services

Services Provided: Case management; outpatient services; emergency/crisis; school consultation

Ages Served: 5-21 years

Capacity: 80 families/80 children

Total Staff: 7 (86% minority)

Population Served:
81% Latino/Hispanic; 13% Caucasian; 5% African American; 1% Asian/Pacific Islanders

Cultural Competence Training:

- Specialized project in collaboration with George Washington University, process based writing groups for children
- Books exchanged with children in El Salvador
- El Salvador tour presentation on current issues
- Issues of child/adolescent development and behavioral management

Treatment Philosophy:

- To promote a positive bicultural identity
- Services provided within the context of cultural transition
- Prevention of adjustment problems in school
- Treat child in context of family
- Advocate for appropriate services
- Sensitivity to cultural barriers which impact on access to services

Cultural Competence Strategies:

- Telephone answered in Spanish
- Personal contact rather than paper work is emphasized
- Emphasis on the family unit
- Home visits
- Volunteers
- Assistance with multiple needs
- Focus on cultural values
- Provide information to raise cultural sensitivity among non-Hispanic school staff
- Culturally relevant decor
- School-based services

Columbus Area Community Mental Health Center MECCA (Multi Cultural East Side Center of the Columbus Area)
Columbus, Ohio

Private, non-profit mainstream agency providing outreach services to minority people

Services Provided: Case management; outreach

Ages Served: 12-18 years

Capacity: 45 families/45 children

Total Staff: 4 (75% minority)

Population Served: 100% African American

Cultural Competence Training:

- Culturally appropriate videos are available and encouraged
- Propose to consult with a nationally recognized expert on cultural issues
- Inservices

Treatment Philosophy:

- Community based
- Client centered
- Flexibility
- Systems approach
- Emphasis on self-determination

Cultural Competence Strategies:

- Outreach into homes
- Recruit churches
- Educational parenting groups without the need to sign up for treatment
- Black video to stimulate discussion
- Changed name to reduce stigma
- Use of advisory boards with minority members
- Program located in recreational center

AGENCY PROFILES

Colville Tribes Mental Health Program
Nespelem, Washington

Public, mainstream agency supporting services by minorities within minority communities

Services Provided: Outreach; emergency/crisis; outpatient services; case management

Ages Served: 0-18 years

Capacity: 8-10 families/8-10 children

Total Staff: 5 (80% minority)

Population Served: 99% Native American; 1% Caucasian

Cultural Competence Training:

- Ongoing cultural sensitivity training as needed

Treatment Philosophy:

- Focus on strengths
- Treat the whole family
- Examine ties to immediate and extended family

Cultural Competence Strategies:

- Indian paintings
- Respect for extended family
- Use of natural healers, traditional medicine men and healing ceremonies
- Attitude of caring and acceptance
- Staff with understanding of culture
- Accessible location on reservation

Community Based Services, Inc.
Family Advocacy Program
Fairfax, Virginia

Mainstream, private, non-profit agency providing outreach services to minority people

Services Provided: Case management; outreach; emergency/crisis; intensive home based

Ages Served: 0-21 years

Capacity: 150 families/450 children

Total Staff: 55 (49% minority)

Population Served: 50% Caucasian; 35% African American; 10% Latino/Hispanic; 5% Asian/Pacific Islanders

Cultural Competence Training:

- Weekly inservices often focus on cultural issues such as Asian assimilation in the U.S., religious heritage
  Staff participate in outside training on multicultural issues

Treatment Philosophy:

- Competency-based treatment
- Focus on strengths
- Normalization of family life
- Individualized treatment

Cultural Competence Strategies:

- Treatment takes place in home
- Use of natural support system
- Respect for extended family
- Respect for social roles of household members
- Multicultural staff

AGENCY PROFILES

Connections Catholic Charities
Falls Church, Virginia

Private, non-profit agency providing bilingual, bicultural services

Services Provided: Case management; outreach; respite; outpatient services; emergency/crisis; therapeutic foster care; home based; adoption

Ages Served: 3-21 years

Capacity: 100 families/200 children

Total Staff: 46 (65% minority)

Population Served: 60% Asian/Pacific Islanders; 30% Latino/Hispanic; 5% African American; 5% Caucasian

Cultural Competence Training:

- Weekly inservice on cross-cultural issues; sessions are one and a half hours

Treatment Philosophy:

- Treat the whole person
- Address concrete needs as well as psychological needs
- Focus on preserving families
- Respect elements of clients' culture, such as sex roles
- Link with other agencies

Cultural Competence Strategies:

- Use of nontraditional helpers such as Buddhist Monks
- Participate in ethnic-specific community social functions
- Sponsor newsletter in language of clients
- Case management model for minority children
- Agency located in heart of refugee community
- Culturally specific decor

D.C. Commission on Mental Health
ACCESS Central Intake Unit
Washington, D.C.

Public agency supporting services by minorities within a minority community

Services Provided: Case management; emergency/crisis; outreach

Ages Served: 5-17 years

Capacity: 70 families/70 children

Total Staff: 14 (79% minority)

Population Served: 95% African American; 5% Latino/Hispanic

Cultural Competence Training:

- Half-day inservices on cultural competence utilizing CASSP model
- Sections of the cultural competence monograph have been distributed to staff
- Inservices, preservices are done periodically for all staff

Treatment Philosophy:

- No reject policy
- Treat child and family as a unit
- Involve support system
- Take into consideration that child may be underdeveloped because of violence

Cultural Competence Strategies:

- Take services to clients (home, school, etc.)
- Use culturally appropriate pictures and posters
- Assess positive aspects of culture
- Minority staff serve as role models
- Focus on building self-esteem
- Genograms
- Consider child-rearing practices
- Recognize the importance of religion and the church

AGENCY PROFILES

D.C. Commission on Mental Health
Paul Robeson School for
Growth and Development
Washington, D.C.

Public mainstream agency supporting services by minorities within a minority community

Services Provided: Day treatment

Ages Served: 6-12 years

Capacity: 32 families/32 children

Total Staff: 22 (77% minority)

Population Served: 100% African American

Cultural Competence Training:

- No formal specialized culturally focused training; however, cultural issues are discussed

Treatment Philosophy:

- Psycho-educational program which uses a multidisciplinary approach
- Holistic approach
- Family most important aspect of a child's life
- Treatment environment is well supervised, highly structured, safe, and nurturing

Cultural Competence Strategies:

- Culturally relevant paintings and posters
- Discussion groups with parents who share customs and traditions
- Use of volunteers and natural support systems, such as college students and ministers
- Recognizes gender expectations of children
- Culturally specific programs/activities
- Located in black community
- Focus on acculturation and subcultural issues

Denver Indian Health & Family Services
Denver, Colorado

Private, non-profit minority agency providing services to minority people

Services Provided: Outreach; outpatient services

Ages Served: 2-18 years

Capacity: 171 children since May '88

Total Staff: 5 (80% minority)

Population Served: 100% Native American

Cultural Competence Training:

- Consultant serves as facilitator to deal with cultural issues on monthly basis

Treatment Philosophy:

- Provide culturally sensitive services
- Holistic approach
- Encourage independence
- Multidisciplinary team approach

Cultural Competence Strategies:

- Preference for hiring Indian staff
- Staff serves as role models
- Serve any American Indian regardless of residency
- Will use traditional helpers
- Respect for cultural differences
- Respect for confidentiality
- Degree of acculturation is assessed
- Accessible location

AGENCY PROFILES

Eastern Nebraska Community Office of Mental Health Youth Services
Omaha, Nebraska

Private, non-profit mainstream agency

Services Provided: Case management; outreach; home based; emergency/ crisis; day treatment; residential treatment; therapeutic; foster care

Ages Served: 6-21 years

Capacity: 172 families/292 children

Total Staff: 128 (12% minority)

Population Served: 76% Caucasian; 19% African American; 2% Asian/Pacific Islanders; 2% Native American; 1% Latino/Hispanic

Cultural Competence Training:

- Minority community leaders provide training on issues to staff
- Training is done periodically and lasts for two hours

Treatment Philosophy:

- To support the integrity of the family
- To reunify the family
- Empower families

Cultural Competence Strategies:

- Respect for the extended family systems
- Cultural issues such as child-rearing practices and neighborhood norms are respected and valued
- Consumer satisfaction results are reviewed by board
- Staff assignments based on cultural sensitivity
- Involve parents in every aspect of service delivery
- Clients' rights manual

Exchange Club of Vicksburg
Child Abuse Prevention Center
Vicksburg, Mississippi

Private, non-profit mainstream agency

Services Provided: Case management; outreach; outpatient; emergency/crisis

Ages Served: 0-15 years

Capacity: 40 families

Total Staff: 3 (33% minority)

Population Served: 50% African American; 50% Caucasian

Cultural Competence Training:

- A values clarification process is part of parent volunteer training -- 1.5 hours, 4 times a year
- Inservices are held every other month

Treatment Philosophy:

- Separate person from behavior
- Client participation in treatment planning
- Multi-disciplinary team approach
- Individualized treatment

Cultural Competence Strategies:

- Culturally specific posters
- Facility is accessible
- Attitude of openness and kindness
- Use of natural support systems such as parent aide volunteers
- Same sex interventions promoted
- Staff sensitive to racial/cultural differences

AGENCY PROFILES

Exchange Club Parent/Child Center
Jackson, Mississippi

Private, non-profit, mainstream agency

Services Provided: Outreach; case management

Ages Served: 0-12 years

Capacity: 137 families/182 children

Total Staff: 11 (36% minority)

Population Served: 90% African American; 10% Caucasian

Cultural Competence Training:

- Ongoing

Treatment Philosophy:

- Promote positive parenting
- Prevent child abuse
- Provide educational and emotional support

Cultural Competence Strategies:

- Home-based services
- Services delivered in a dignified and positive manner
- Parent aide volunteers
- Accessible location

Family Advocacy and Support Association, Inc.
Washington, D.C.

Private, non-profit, minority program providing services to minority people

Services Provided: Outreach; family support; educational/advocacy

Ages Served: 0-21 years

Capacity: Unlimited number of families

Total Staff: 1 (100% minority)

Population Served: 95% African American; 5% Caucasian

Cultural Competence Training:

N.A.

Treatment Philosophy:

- Parent support group
- Peer counseling
- Include children in structured family activities
- Improve coping capacity
- Provide educational services

Cultural Competence Strategies:

- Respect for Afrocentric perspective
- Culturally appropriate pictures and paintings
- Accessible location
- Refreshments at meetings
- Opportunity for socialization provided
- Provide appropriate information to local schools, mental health facilities, etc.

AGENCY PROFILES

The Family Place, Inc.
Washington, D.C.

Private, non-profit agency providing bilingual/bicultural services

Services Provided: Case management; outreach; outpatient services; respite care; emergency/crisis; day treatment; physical therapy for handicapped babies

Ages Served: Prenatal-3 years

Capacity: 200 families per month/15-25 children daily

Total Staff: 15 (93% minority)

Population Served:
94% Latino/Hispanic; 5% African American; 1% Caucasian

Cultural Competence Training:

- Ongoing inservice for all direct service staff in such areas as post-traumatic stress, transcultural counseling, use and abuse of alcohol in Latino/Hispanic families
- Cultural aspects of services are explored at staff meetings/retreats

Treatment Philosophy:

- Early intervention to help parents exercise their full responsibility as parents
- To provide culturally appropriate psychosocial, educational and support services to strengthen and stabilize family structures
- Prevention

Cultural Competence Strategies:

- Program located in the heart of the Latino/Hispanic community
- Culturally relevant posters and wall hangings in the facility
- Respite care utilized to reproduce the extended family situation
- Home and hospital visits made to determine health status of clients
- Concrete services provided for African Americans who choose not to be involved in a Spanish-speaking environment
- Bilingual/bicultural staff
- Level of acculturation is assessed
- Use of natural support systems such as pairing experienced mothers with first time pregnant women

Family Resource Centers
Project Inroads
Lima, Ohio

Private, non-profit, mainstream agency supporting services by minorities within minority communities

Services Provided: Case management; outpatient; outreach; residential treatment; respite care; emergency/crisis; inpatient

Ages Served: 13-17 years

Capacity: 150 families/54 children per year

Total Staff: 8 (88% minority)

Population Served: 100% African American

Cultural Competence Training:

- Use of consultants
- Outside agency training
- Each staff receives culturally specific training

Treatment Philosophy:

- Adjust program to meet needs of people who have been subjected to racism
- Focus on cultural assessments

Cultural Competence Strategies:

- Culturally appropriate literature and pictures
- Use of extended family
- Natural support systems
- Nontraditional helpers such as ministers
- Define family broadly, including non-blood members

AGENCY PROFILES

Family Service Center
Red Horse Lodge, Inc.
Fort Thompson, South Dakota

Private, non-profit agency supporting services by minorities in a minority community

Services Provided: Case management; outreach; outpatient; emergency/crisis; therapeutic group home; residential treatment

Ages Served: 12-18 years

Capacity: 20 families/60 children

Total Staff: 16 (75% minority)

Population Served: 100% Native American

Cultural Competence Training:

- Yearly training on the "Red Road" approach to healing (an alcohol and drug treatment method)
- Respect for the belief and value systems of other people
- Native American curriculum has been developed

Treatment Philosophy:

- Children have a right to physical, emotional, spiritual, educational, and cultural guidance
- Provide holistic-oriented treatment
- Support Native American culture and beliefs

Cultural Competence Strategies:

- Indian art work
- Community volunteers
- Center serves as a hub for community activities
- Nontraditional helpers conduct Sweat ceremonies
- Role modeling by staff
- Recognition of the importance of Native American religion, parenting, etc., in order to provide effective treatment
- Located on reservation

Fordham & Tremont Community
Mental Health Clinic
Child, Adolescent & Family Services Division
Bronx, New York

Public agency providing bilingual/bicultural services

Services Provided: Outreach; outpatient services; emergency/crisis

Ages Served: 18 months-18 years

Capacity: 150 families/175 children per month

Total Staff: 50 (68% minority)

Population Served:
54% Latino/Hispanic; 44% African American; 1% Asian/Pacific Islanders; 1% Caucasian

Cultural Competence Training:

- Culturally focused training for all staff
- Outside speakers are obtained as needed

Treatment Philosophy:

- Multicultural psychosocial eclectic approach
- Family centered
- Systems approach

Cultural Competence Strategies:

- Use of photos of minority athletes and musicians
- Accessible locations
- Posters of children interacting with each other
- Nontraditional helpers as consultants ("Root Doctors," Godmothers)
- Respect for extended family and religious background
- Level of acculturation is considered

AGENCY PROFILES

Franklin County Juvenile Court
New Directions & Youth Leadership Program
Columbus, Ohio

Public, mainstream agency supporting services by minorities within minority communities

Services Provided: Case management; emergency/crisis; prevention/education; outreach

Ages Served: 8-28 years

Capacity: 100 families/165 children

Total Staff: 6 (100% minority)

Population Served: 98% African American; 2% Caucasian

Cultural Competence Training:

- All staff participate in training every two months for two to three hours; subjects such as child rearing, drug culture, community issues, poverty, etc.

Treatment Philosophy:

- Holistic approach
- Individualized approach with as many services as possible for the family
- Provide as many opportunities as possible for kids to excel

Cultural Competence Strategies:

- Staff serve as role models
- Provide services on site of housing estate
- Build sense of empowerment and leadership within the group
- Provide opportunities for positive peer culture
- Use natural support systems
- Focus on culture, tradition, and education

Vurne Gibbs Health Center
Fort Peck Mental Health
Poplar, Montana

Public, mainstream agency supporting services by minorities within minority communities

Services Provided: Case management; emergency/crisis; consultation; outpatient services; outreach

Ages Served: 0-18 years

Total Staff: 4 (75% minority)

Population Served: 100% Native American

Cultural Competence Training:

- Use of videotapes from Indian reservation
- All staff participate in training on subjects such as aspects of spiritual harmony

Treatment Philosophy:

- Holistic approach
- Involve extended family
- Reservation-based treatment

Cultural Competence Strategies:

- Encourage cultural activities, pow-wows, sweat lodges
- Use of Native American paintings and posters
- Preference for hiring Native American staff
- Natural support systems
- Level of acculturation is considered

AGENCY PROFILES

Good Shepherd Center
Marian Hall Facility
New York, New York

Private, non-profit mainstream agency

Services Provided: Therapeutic foster care; case management; residential treatment

Ages Served: 12-20 years

Capacity: 18 families/18 adolescents

Total Staff: 21 (43% minority)

Population Served: 50% African American; 48% Latino/Hispanic; 2% Caucasian

Cultural Competence Training:

- Inservices for all staff
- Specialized workshops on such subjects as Hispanic culture or black child in placement, etc.

Treatment Philosophy:

- Respect uniqueness and dignity of each person
- Self-determination
- Each individual has the ability to change and grow

Cultural Competence Strategies:

- Monthly programs to celebrate different cultures
- Reinforce the positive aspects of culture
- Accessible location
- Use of neighborhood resources such as National Black Theatre and the Youth Ministry Center for People of Color
- Staff serve as role models

Greater Omaha Community Action, Inc.
North Clinic Family Counseling Services
Omaha, Nebraska

Mainstream public agency

Services Provided: Emergency/crisis; outreach; outpatient services

Ages Served: 0-18 years

Capacity: 60 families/175 children

Total Staff: 6 (98% minority)

Population Served: 51% African American; 47% Caucasian; 2% Native American

Cultural Competence Training:

- Staff attend workshops and reports are provided to all staff
- Special speakers are provided

Treatment Philosophy:

- Provide services based on need, regardless of race, creed or origin
- Individualized treatment

Cultural Competence Strategies:

- Will assign same ethnic group therapist if request is made
- Services accessible to population

AGENCY PROFILES

Harlem Interfaith Counseling Services, Inc.
Self Help Initiative Program and
Mustard Seed Learning Center
New York, New York

Private, non-profit minority agency providing services to minority people

Services Provided: Case management; outreach; training; outpatient

Ages Served: 3-20 years

Capacity: 90 families/220 children

Total Staff: 25 (100% minority)

Population Served: 95% African American; 5% Latino/Hispanic

Cultural Competence Training:

- Staff training is related to whatever is going on in the case load:
  - Today's black families
  - Caribbean culture
  - AIDS training

Treatment Philosophy:

- Emphasize the power of choice
- Prevent as much dysfunction as possible
- Design activities to be supportive of black families
- Focus on health
- Never develop programs unless community indicates a need
- Believe in empowerment

Cultural Competence Strategies:

- Respect the role that the church and religion play in the black community
- Ethnic-oriented art work is used in facility
- Take into account various ways of defining family
- Communicate within the cultural context of families
- Culturally competent staff
- Provide services in the home

Hunts Point Multi-Service Center, Inc.
Mental Health Unit
Bronx, New York

Private, non-profit agency providing bilingual/bicultural services

Services Provided: Outreach; emergency/crisis; outpatient services

Ages Served: 6-18 years

Capacity: 75 families/175 children

Total Staff: 27 (96% minority)

Population Served:
99% Latino/Hispanic; 1% African American

Cultural Competence Training:

N.A.

Treatment Philosophy:

- Interventions based on needs of clients

Cultural Competence Strategies:

- Services are provided on weekends
- Used nontraditional helpers as indicated, such as a voodoo consultant
- Bilingual/bicultural staff
- Level of acculturation is considered

AGENCY PROFILES

Idaho Migrant Council
Migrant Head Start Project
Caldwell, Idaho

Private, non-profit mainstream agency supporting services by minorities within a minority community

Services Provided: Outreach; case management

Ages Served: 6 months-6 years

Capacity: 371 families/583 children

Total Staff: 23 (100% minority)

Population Served: 99% Latino/Hispanic; .5% Caucasian; .5% Native American

Cultural Competence Training:

- Training curriculum for monthly inservices
- Training advisory committee
- Tapes available on such subjects as special needs of migrant children

Treatment Philosophy:

- Early intervention for high-risk children
- Provide atmosphere and environment where culturally relevant mental health services can be provided
- Emphasize prevention
- Family oriented

Cultural Competence Strategies:

- Use of culturally sensitive toys
- Use of Parent Policy Council
- Reduce the stigma of mental health treatment
- Use of specific testing instruments
- Level of acculturation is considered

Indian River MH/MR Center
Insight Center
Tuscaloosa, Alabama

Public agency supporting services by minorities within a minority community

Services Provided: Outreach; outpatient services; case management services

Ages Served: 0-18 years

Capacity: 500 families/1,000 children

Total Staff: 5 (100% minority)

Population Served: 99% African American; 1% Caucasian

Cultural Competence Training:

N.A.

Treatment Philosophy:

- Community-based approach to treatment
- Assess and work with entire family

Cultural Competence Strategies:

- Use professional network for help with 1% of clients who are Caucasian
- Program coordinator is a community leader
- Use black sorority as resource
- Accessible location

AGENCY PROFILES

Indian Walk-In Center
Salt Lake City, Utah

Private, non-profit minority agency providing services to minority people

Services Provided: Outreach; emergency/crisis; counseling

Ages Served: 0-17 years

Capacity: 500 families monthly

Total Staff: 7 (86% minority)

Population Served: 43% Native American; 40.5% Caucasian; 13% Latino/Hispanic; 3% African American; <1% Asian/Pacific Islanders

Cultural Competence Training:

- Special speakers periodically
- All staff participate in training
- Native American Week once a year

Treatment Philosophy:

- Provide for basic needs
- Help Native Americans adjust to urban living
- Individualized approach

Cultural Competence Strategies:

- Ethnic-specific posters
- Use of nontraditional helpers such as spiritual healers
- Elders are involved in monthly pow-wows
- Advocate for clients since Native Americans may be hesitant to speak out to get needs met
- Accessible location
- Cultural-specific activities are provided

Johnston County MH/MR/SA
Children's Services Program
Smithfield, North Carolina

Public mainstream agency

Services Provided: Case management; respite care; outreach; emergency/crisis; therapeutic group home; inpatient services; foster care; residential; day treatment; outpatient

Ages Served: 2-17 years

Capacity: 183 families/183 children

Total Staff: 10 (25% minority)

Population Served: 50% Caucasian; 40% African American; 5% Latino/Hispanic; 3% Asian/Pacific Islanders; 2% Native American

Cultural Competence Training:

- Twice a year inservices focus on minority issues
- Inservices utilize lecture format, questions and answers, videotape
- Weekly supervision may include a focus on a minority culture

Treatment Philosophy:

- Individualized treatment plan
- In-home service
- Emphasis on working with families
- Look at behavior which interferes with function

Cultural Competence Strategies:

- Consider the influence of religion on behavior
- Toys are geared toward minority children
- Consider behavior norms at home and school such as tone of voice, non-verbal interactions
- Transportation for low-income clients
- Accessible location
- Extensive volunteer program

AGENCY PROFILES

La Alianza Hispana, Inc.
Roxbury, Massachusetts

Private, non-profit minority agency providing services to minority people

Services Provided: Case management; outpatient services; outreach; substance abuse; early intervention; day treatment; adoption/foster care

Ages Served: 6-18 years

Capacity: 1,200 families a year; 100 children at any one time

Total Staff: 83 (94% minority)

Population Served: 96% Latino/Hispanic; 4% African American

Cultural Competence Training:

- Cultural issues are discussed during case reviews

Treatment Philosophy:

- Family-oriented continuum of services
- Integrated psychosocial, educative, preventive, and active intervention modalities adapted to clients' cultural, linguistic and socio-emotional characteristics

Cultural Competence Strategies:

- Bicultural and bilingual staff
- Advocacy for equal access to basic resources
- Combat the effects and stresses of migration
- Annual meetings with stakeholders
- Accessible location
- Level of acculturation is considered
- Nontraditional helpers such as college interns

La Frontera
Mental Health and Substance Abuse Services
Tucson, Arizona

Private, non-profit agency providing bilingual/bicultural services

Services Provided: Adolescent day treatment; outpatient services

Ages Served: 0-17 years

Capacity: 800 families/1,000 children annually

Total Staff: 210 (33% of Treatment Staff, 33% of Administrative Staff, and 62% of Support Staff are minorities)

Population Served: 50% Caucasian; 40% Latino/Hispanic; 5% African American; 5% Native American

Cultural Competence Training:

- Inservices by senior staff and available to all staff in once-a-month, two-hour sessions
- Content of training includes variations in Latino/Hispanic backgrounds, generational differences, gender differences; interaction between cultural and socioeconomic status

Treatment Philosophy:

- Mental health services are needed and essential
- Services must be provided within a cultural context
- Treatment must be flexible
- Work with family within the child's social system
- Support as well as treatment is necessary

Cultural Competence Strategies:

- Recruitment of cultural minority staff from community
- Bilingual literature and signs
- Agency facility built with community contributions
- Sponsors annual music festival, a southwestern cultural event
- Culturally relevant programs
- Minority members at policymaking and administrative levels
- Level of acculturation is assessed
- Accessible location

AGENCY PROFILES

Los Angeles Child Guidance Clinic
Day Treatment Programs/Non-Public School
Los Angeles, California

Private, non-profit agency providing bilingual/bicultural services

Services Provided: Day treatment; outpatient services

Ages Served: 12-21 years

Capacity: 36 families/36 children

Total Staff: 25 (56% minority)

Population Served: 58% African American; 36% Latino/Hispanic; 3% Asian/Pacific Islanders; 3% Caucasian

Cultural Competence Training:

- Budget for outside training
- Special consultation as needed
- Avoid culturally biased training/material
- Inservices unique to population served (Latino/Hispanic households or work with black families)

Treatment Philosophy:

- Equal access to quality care
- Family-focused treatment
- Tailor services/activities so that low-income families are included
- Pay for any activity that costs money, i.e., trips to Disneyland

Cultural Competence Strategies:

- Match staff to client in terms of ethnicity
- Use of nontraditional helpers, such as "Hispanic elders" who function like grandmothers
- Observe culturally relevant dates
- Consider testing bias
- Recognize the importance of the extended family
- Behavior is considered within a cultural and social reality context

Lutheran Medical Center
Sunset Park Mental Health Center
Brooklyn, New York

Private, non-profit agency providing bilingual/bicultural services

Services Provided: Day treatment; outpatient services

Ages Served: 4-13 years

Capacity: 20-25 families/40-50 children a day

Total Staff: 60 (75% minority)

Population Served: 80% Latino/Hispanic; 16% Caucasian; 2% African American; 2% Asian/Pacific Islanders

Cultural Competence Training:

- One hour weekly inservice by speakers with expertise in mental health services to Latinos/Hispanics

Treatment Philosophy:

- Ultimate answer to the treatment and curability of mental illness depends on the quality of care and effectiveness of treatment, and the elimination of cultural and language barriers which prevent Hispanics from utilizing mental health services

Cultural Competence Strategies:

- Ethnic-specific posters, paintings and pictures
- Bilingual/bicultural services
- Use of culturally specific testing instrument (TEMAS test)
- Cuento therapy, culturally sensitive modality developed in conjunction with the Hispanic Research Center
- Home visits
- Provide transportation
- Match clinician to client
- On-site school programs
- Use of paraprofessional and professional staff
- Nondiscriminatory admission policy

AGENCY PROFILES

MAAT Center for Human and Organizational Enhancement
Washington, D.C.

Private, non-profit minority agency providing services to minority people

Services Provided: Outreach; case management; outpatient services

Ages Served: 4-22 years

Capacity: 50 families/75 children

Total Staff: 8 (100% minority)

Population Served: 99% African American; 1% Caucasian

Cultural Competence Training:

- Afrocentric optimal functioning cultural training model
- Afrocentric intervention techniques
- Interservices weekly for all new staff
- Modules for working with African American families

Treatment Philosophy:

- Afrocentric
- Humanistic and naturalistic orientation focused on the value of positive interaction
- Work on psychological, spiritual and mental development
- Incorporate developmental process into work
- Incorporate rites of passage for African American adolescents

Cultural Competence Strategies:

- Extended family network
- Reading material is African American
- African art in facility
- Staff serves as role models and extended family members
- Accessible location
- Spiritual and religious orientation
- Community bulletin board contains cultural and political material
- Level of acculturation is assessed
- Highly credentialed staff serve as non-traditional helpers

Memphis Mental Health Institute Child and Adolescent Inpatient Psychiatric Unit
Memphis, Tennessee

Public mainstream agency

Services Provided: Inpatient

Ages Served: 5-18 years

Capacity: 69 children

Total Staff: 69 (64% minority)

Population Served: 63% African American; 36% Caucasian; 1% Asian/Pacific Islanders

Cultural Competence Training:

- Three-part series on managing diversity
- Multicultural team to meet informally and discuss bias observed in their facility

Treatment Philosophy:

- Multidisciplinary approach
- Individualized treatment
- Utilize family strengths
- Referrals are screened regardless of background

Cultural Competence Strategies:

- Use community facilities
- Bi-racial toys in children's unit
- Community volunteers from Urban League, etc.
- Accessible location

AGENCY PROFILES

Middle Georgia Council on Drugs
Music-Oriented Values Education Program
Governor's High Risk Youth Teen Center
Macon, Georgia

Private, non-profit mainstream agency

Services Provided: Outpatient services; outreach; case management

Ages Served: 12-18 years

Capacity: 35 families/100 teens

Total Staff: 8 (63% minority)

Population Served: 100% African American

Cultural Competence Training:

- Weekly staff meetings in which there is some focus on cultural issues
- Role playing
- Workshops on such subjects as substance abuse and AIDS

Treatment Philosophy:

- Prevention of substance abuse and AIDS
- Services based on need
- Involve clients in treatment process from planning to evaluation

Cultural Competence Strategies:

- Affirmative action agency
- Agency accessible to public transportation
- Reduce stigma by locating facility in a commercial building

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Midtown Mental Health Center
Children and Youth Department
Memphis, Tennessee

Private, non-profit mainstream agency

Services Provided: Outpatient services

Ages Served: 3-17 years

Capacity: 140 children

Total Staff: 4 (75% minority)

Population Served: 95% African American; 5% Caucasian

Cultural Competence Training:

N.A.

Treatment Philosophy:

- All individuals are treated equally
- Total person is treated based on needs
- Treatment goals are individualized

Cultural Competence Strategies:

- Staff selected based on experience in working with minority and multi-cultural populations
- Parents and volunteers are utilized for recreational and educational activities
- Accessible location

AGENCY PROFILES

Mother Dear's Community Center
Washington, D.C.

Private, non-profit minority agency providing services to minority people

Services Provided: Outreach; concrete services such as food, clothing, tutoring, and counseling

Ages Served: 0-21 years

Capacity: 50+ families/50+ children

Total Staff: 3 (100% minority)

Population Served: 99% African American; 1% Latino/Hispanic

Cultural Competence Training:

N.A.

Treatment Philosophy:

- Treat people with respect and dignity
- Services provided based on request rather than "means test" or whether receiving governmental assistance
- Motto -- "Destiny makes us brothers. If you lift someone up, we'll all rise together."

Cultural Competence Strategies:

- Use of student volunteers; homeless person provides custodial and office coverage
- Respect for client's religious background
- Spiritual uplifting from inspirational music
- Expose clients to cultural activities
- Instill traditional values from black families
- Flexible hours
- Support subgroups with the black community

Mujeres Latinas EN ACCION
SASS (Screening, Assessment, Supportive Services)
Chicago, Illinois

Private, non-profit agency providing bilingual/bicultural services

Services Provided: Case management; outreach; advocacy; emergency/crisis; Latino Leadership Program for Women; counseling

Ages Served: 0-17 years

Capacity: 30 families/30 children

Total Staff: 8 (63% minority)

Population Served:
95% Latino/Hispanic; 3% Caucasian; 1% African American; 1% Native American

Cultural Competence Training:

- All training geared toward serving the Latino/Hispanic population
- Training twice a month on such subjects as alcoholism in Latino/Hispanic families, child development, etc.

Treatment Philosophy:

- Empower clients
- Help parents to remain parents
- Coordinate with other agencies

Cultural Competence Strategies:

- Respect the strong male role in Hispanic families
- Bilingual literature
- Employ bilingual/bicultural staff
- Participate in ethic oriented activities
- Accessible location
- Level of acculturation is considered

AGENCY PROFILES

Northside Center for Child Development
New York, New York

Private, non-profit minority agency providing services to minority people

Services Provided: Outreach; day treatment; outpatient services

Ages Served: 15 months-16 years

Capacity: 200 families/300 children

Total Staff: 84 (78% minority)

Population Served: 50% African American; 50% Latino/Hispanic

Cultural Competence Training:

- Training for all staff on cross-cultural issues such as fathers and children in treatment, ethnicity, cultural and mental health, influence of spiritualism in Latin community

Treatment Philosophy:

- Holistic approach
- Multidisciplinary approach
- Mission statement speaks to needs of Latinos/Hispanics and blacks and developmental difficulties created by discrimination, oppression and racism
- Combine clinical and educational intervention

Cultural Competence Strategies:

- Library includes weekly programs with cultural focus
- Has Hispanic mothers group
- Use nontraditional helpers, such as Foster Grandparents
- Interventions within the classroom

Okanogan County Mental Health
Okanogan County RE-ED Program
Omar, Washington

Public, mainstream agency

Services Provided: Case management; emergency/crisis; day treatment; outpatient services; outreach

Ages Served: 12-18 years

Capacity: 15-18 families/15-18 children

Total Staff: 7 (14% minority)

Population Served: 60% Native American; 40% Caucasian

Cultural Competence Training:

- Ongoing training
- Supervisors have lived on reservation and are able to help staff learn about culture-specific behavior

Treatment Philosophy:

- Work with entire system
- Trust and respect are leading considerations
- Do not isolate the kid as the problem

Cultural Competence Strategies:

- Attention given to family standards
- Native American posters on display
- Work with tribal child welfare and tribal mental health systems
- Work with extended family
- Respect for traditional belief system
- Level of acculturation is carefully examined
- Use of natural support systems

AGENCY PROFILES

Payne Chapel AME Church
Alcoholism Screening and Knowledge
Nashville, Tennessee

Private, non-profit minority agency providing services to minority people

Services Provided: Case management; outpatient services; drug and alcohol; early intervention

Ages Served: 12-16 years

Capacity: 40-60 families/40-60 children

Total Staff: 4 (100% minority)

Population Served: 100% African American

Cultural Competence Training:

- Annual inservices for teachers which include cultural issues

Treatment Philosophy:

- Services based on needs of black youth
- Incorporate black spiritual and moral values into treatment approaches
- Impose discipline and rules to increase self-esteem and mastery
- Focus on survival and communication skills

Cultural Competence Strategies:

- Incentives to make programs attractive
  - no individual sessions
  - no discharges
- Offices in church setting
- Parent volunteer program
- Provide culturally relevant services
- Church board of directors

Puerto Rican Family Institute
Queens Mental Health Clinic
New York, New York

Private, for-profit minority agency providing services to minority people

Services Provided: Case management; outpatient services

Ages Served: 5-18 years

Capacity: 240 client contacts monthly

Total Staff: 9 (100% minority)

Population Served: 100% Latino/Hispanic

Cultural Competence Training:

- Provides culturally relevant training for other service providers, staff and consumers of service, etc.

Treatment Philosophy:

- Quality services require the capacity for service providers to understand the language and culture of the population

Cultural Competence Strategies:

- Sponsor meetings focusing on Hispanic culture
- Involvement in community activities
- Posters and pictures depict Latin images
- Announcements are in Spanish
- Tailor services to Latino/Hispanic population
- Bilingual/bicultural staff
- Use of media for culture-specific information

AGENCY PROFILES

Salt Lake Valley Mental Health
Refugee Mental Health Program
Salt Lake City, Utah

Private, non-profit agency providing bilingual/bicultural services

Services Provided: Case management; outreach; respite care; therapeutic group home; inpatient; emergency/ crisis; day treatment; outpatient services; residential treatment

Ages Served: 8-17 years

Capacity: 20 families/20 children

Total Staff: 10 (90% minority)

Population Served: 100% Asian/Pacific Islanders

Cultural Competence Training:

- Videotapes, lectures, role playing, etc.
- Sixteen hour training sessions on such subjects as cultural factors affecting treatment; how to work with the Asian community; and mental health systems in refugee countries
  Provide training on post-traumatic stress and depression among Asians, etc.

Treatment Philosophy:

- Offer services in a non-threatening and culturally sensitive way
- Provide outreach and translation services as needed
- Clients have a right to receive needed services

Cultural Competence Strategies:

- Information provided in various Asian languages
- Use nontraditional helpers, such as priests and monks
- Subcontract with minority community organizations or provide outreach and translation services, etc.
- Asian decor
- Individual and collateral therapy in preparation for family therapy
- Provide technical assistance and consultation to other agencies
- Accessible location
- Level of acculturation is evaluated

San Fernando Valley Child Guidance Clinic
Northridge, California

Private, non-profit agency providing bilingual/bicultural services

Services Provided: Case management; group home; parent education; emergency/crisis; day treatment; outpatient services; outreach

Ages Served: 0-18 years

Capacity: 300 families/750 children weekly

Total Staff: 127 (40% minority)

Population Served: 48% Caucasian; 35% Latino/Hispanic; 10% African American; 6% Asian/Pacific Islanders; 1% Native American

Cultural Competence Training:

- APA approved training program
- Ethnic minority task force for training content
- All staff must attend training
- Good mix of racial groups as trainees

Treatment Philosophy:

- Prevention of mental illness and school problems
- Work in natural environment (home or school)
- Early intervention prevents more serious disturbances later in life

Cultural Competence Strategies:

- Volunteers
- Home visits by bilingual/bicultural staff
- Consider different ways of defining family
- Tutorial program
- Parent education, child abuse videotape in Spanish
- Bilingual services
- Brochures and admission applications available in Spanish and Asian languages
- Community-based services
- Hispanic Outreach Program -- 98% Hispanic
- Recognize the importance of maintaining ethnic origin

AGENCY PROFILES

SERVICIOS de la Raza, Inc.
Youth Services Division
Denver, Colorado

Private, non-profit agency supporting services by minorities within a minority community

Services Provided: Emergency/crisis; outpatient; outreach; educational employment services

Ages Served: 5-21 years

Capacity: 880 families/2,199 children and adolescents

Total Staff: 8 (87% minority)

Population Served:
95% Latino/Hispanic; 2% Caucasian; 1% African American; 1% Asian/Pacific Islanders; 1% Native American

Cultural Competence Training:

- Periodically bring in national experts on cultural issues

Treatment Philosophy:

- Meet emergency needs first
- Joining cognitive mental health proficiency with cultural uniqueness of population

Cultural Competence Strategies:

- Address Latino/Hispanic cultural uniqueness
- Assess degree of acculturation
- Bilingual receptionists
- Location in Latino/Hispanic neighborhood
- Staff assignments based on culture
- Hispanic decor
- Natural support system (folk healers)

Smokey Mountain Area Mental Health, Developmental Disabilities, and Substance Abuse Services
Dillsboro, North Carolina

Public mainstream agency

Services Provided: Case management; foster care; respite care; emergency/crisis; inpatient; outreach; group home; day treatment; outpatient services

Ages Served: 0-18 years

Capacity: 400 families/750 children (approx.)

Total Staff: 184 (0.2% minority)

Population Served: 92.4% Caucasian; 5.3% Native American; 1.8% African American; .01% Asian/Pacific Islanders; .01% Latino/Hispanic

Cultural Competence Training:

N.A.

Treatment Philosophy:

- Family and community focused
- Flexible approach to allow maximum self-determination
- Sensitivity to issues of confidentiality
- Providing consultation to reservation

Cultural Competence Strategies:

- Include extended family
- Physical facility serving Native American population was jointly funded by the county and the tribal government
- Ethnic-specific decoration
- Respect client's desire to seek non-traditional helpers
- Respect cultural-specific child-rearing practices
- Support nontraditional activities such as "Talking Circles"

AGENCY PROFILES

South Central Fulton Community Mental Health Center
Child and Adolescent Program
Atlanta, Georgia

Public, mainstream agency supporting services by minorities within a minority community

Services Provided: Case management; day treatment; respite care; outpatient; emergency/crisis

Ages Served: 2-18 years

Capacity: 200 families/300 children

Total Staff: 7 (86% minority)

Population Served: 80% African American; 15% Caucasian; 5% Latino/Hispanic

Cultural Competence Training:

- All staff must take culturally focused training, including orientation sessions and ongoing training
- Off-site seminars

Treatment Philosophy:

- Value community support network
- Utilize practical approach

Cultural Competence Strategies:

- Volunteers from the community
- Concrete services
- Cultural norms of family/community are considered
- Facility located in multiagency building
- Culturally specific toys, posters and paintings
- Brochures in Spanish

South Dade Community Mental Health
Therapeutic Foster Care and Project Support
Miami, Florida

Private, non-profit mainstream agency

Services Provided: Case management; outreach; group home; emergency/crisis; inpatient services; day treatment; foster care; outpatient services; residential treatment

Ages Served: 0-17 years

Capacity: 15 families/20 children

Total Staff: 7 (83% minority)

Population Served: 50% Latino/Hispanic; 49% African American; 1% Caucasian

Cultural Competence Training:

- Training to foster families is provided (ethnic-specific foods, language barriers, etc.)

Treatment Philosophy:

- Nurturing environment
- Community-based care
- Prevention of child neglect and abuse

Cultural Competence Strategies:

- Handouts and brochures in Spanish and Creole
- Consider ethnic-specific child-rearing practices
- Outreach workers from same ethnic group
- Value religious freedom
- Culturally relevant toys
- Celebrate culturally relevant holidays
- Accessible location
- Artwork by children themselves

AGENCY PROFILES

St. Joseph Hospital
Southeast Asian Support Center
Providence, Rhode Island

Private, non-profit agency providing bilingual/bicultural services

Services Provided: Case management; emergency/crisis; inpatient; outreach; outpatient services

Ages Served: 4-19 years

Capacity: 70 families/30 children

Total Staff: 5 (80% minority)

Population Served: 100% Asian/Pacific Islanders

Cultural Competence Training:

- Culturally focused inservice training
- Multicultural training by bilingual staff
- Brought people in who have worked in refugee camps
- Ethnic tension conference

Treatment Philosophy:

- Holistic approach
- Highly trained staff
- Team approach

Cultural Competence Strategies:

- Utilize bilingual team
- Respect belief system of clients
- Participate in local celebrations
- Home visits
- Flexibility in treatment site
- Encourage clients to practice own religion
- Level of acculturation is considered
- Support the use of nontraditional helpers

Surry-Yadkin MH/MR/SA
Willie M. and Early Intervention Programs
Yadkinville, North Carolina

Public mainstream agency

Services Provided: Case management; outpatient; supervised independent apartment living; outreach; emergency/crisis

Ages Served: 2-18 years

Capacity: 42 children (Willie M. age range is 7-18 years; capacity expands to meet the need. At the time of this study, the Early Intervention Center was serving 42 children)

Total Staff: 31 (22.5% minority)

Population Served: 78.5% Caucasian; 18% African American; 3.5% Latino/Hispanic

Cultural Competence Training:

- One of the managers integrates cultural awareness in informal and formal discussions

Treatment Philosophy:

- Services tailored to need
- Follow legal mandate to provide whatever it takes to guarantee client's success
- Least restrictive setting

Cultural Competence Strategies:

- Positive same-race role models
- Work with churches
- Use of volunteers such as Big Brothers and Big Sisters
- In Early Intervention Program, males provide direct care for young children

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AGENCY PROFILES

Tolyabe Indian Health Project
Family Services Program
Bishop, California

Public agency supporting services by minorities within a minority community

Services Provided: Case management; outpatient; residential; group home; outreach; foster care

Ages Served: 0-18 years

Capacity: 140 families/150 children

Total Staff: 11 (90% minority)

Population Served: 95% Native American; 5% Caucasian

Cultural Competence Training:

- Quarterly training is culturally focused
- Four-day training sessions on how culture can be used to meet AA 12 Steps
- Annual health conferences

Treatment Philosophy:

- Use cultural strengths
- Avoid mental health jargon
- "Start where the client is"
- Respect cultural values

Cultural Competence Strategies:

- Home-based services
- Use natural helpers
- Community ownership of issues
- Reservation-based accessible location

Trend Community Mental Health Services
Family Resource Program
Brevard, North Carolina

Public mainstream agency

Services Provided: Outreach; case management; emergency/crisis; outpatient services

Ages Served: 0-3 years

Capacity: 42 families/50 children

Total Staff: 4 (0% minority)

Population Served: 90% Caucasian; 10% African American

Cultural Competence Training:

- Training emphasizes respect for other cultures

Treatment Philosophy:

- Individualized services
- Work in partnerships with parents
- Parents are primary resources for their infants/toddlers

Cultural Competence Strategies:

- Cognizant and sensitive to Appalachian cultural norms
- Homed-based services
- Respect for extended family
- Use of natural support systems such as taxi drivers and school bus drivers

AGENCY PROFILES

Tressler Centers
Daylight Community Program
Wilmington, Delaware

Private, non-profit agency providing bicultural/bilingual services

Services Provided: Case management; outreach; day treatment

Ages Served: 13-18 years

Capacity: 15 families/15 children

Total Staff: 15 (46% minority)

Population Served: 40% African American; 40% Caucasian; 20% Latino/Hispanic

Cultural Competence Training:

- Speakers on cultural issues every three months
- Multicultural training

Treatment Philosophy:

- Holistic services
- Treatment plan reflects the uniqueness of the individual
- Least restrictive settings
- Empower parents
- Focus on understanding other cultures

Cultural Competence Strategies:

- Agency policy of celebrating cultural diversity; teach black history, etc.
- Nontraditional helpers such as folk healers are discussed
- Rites of passage for African Americans
- Agency location (in YMCA) reduces stigma
- Multicultural staff
- Consider level of acculturation

Tri-County Children and Family Services
Covington, Tennessee

Private, non-profit minority agency providing services to minority people

Services Provided: Outreach; case management; day care; preschool; pregnancy prevention

Ages Served: 0-18 years

Capacity: 500 families/196 children

Total Staff: 28 (85% minority)

Population Served: 91% African American; 9% Caucasian

Cultural Competence Training:

- Consultant provides training on cultural issues, quarterly
- Also, Board training

Treatment Philosophy:

- Offer a continuum of services to families before and after at-risk situation, as well as during crisis
- Work with child, parent, family and community toward a healthier family and community environment
- Offer community-based services responsive to need
- Treat each family with respect
- Child abuse prevention
- Treat child in family context
- Individualized service plan
- Prevention and early intervention

Cultural Competence Strategies:

- Utilize home visitors and natural helpers
- Parent training
- Use of volunteers such as Miss Black America
- Community ownership of building and grass roots advocacy and leadership
- Culturally based treatment
- Family focused
- Cultural aspects are considered in all program activities
- Ethnic-specific pictures

AGENCY PROFILES

UCLA Neuro-Psychiatric Institute
Delta Sigma Theta Head Start Program
Los Angeles, California

Public mainstream agency supporting services by minorities within minority communities

Services Provided: Case management; outreach, inpatient/outpatient services; emergency/crisis; day treatment

Ages Served: 3-5 years

Capacity: 100 families/100 children

Total Staff: 6 (66% minority)

Population Served: 70% African American; 25% Latino/Hispanic; 5% Caucasian

Cultural Competence Training:

- All staff participate in cultural competence training addressing subjects such as cultural awareness

Treatment Philosophy:

- Early identification
- Comprehensive services

Cultural Competence Strategies:

- Assign staff from same ethnic/cultural group
- Culture-specific posters
- Parent education groups provided by African American sorority
- Belief systems of clients are respected
- Head Start Board is 100% minority
- Spanish language used as appropriate
- Level of acculturation is considered
- Accessible location with transportation provided

Union of Pan Asian Communities
Counseling and Treatment Center
San Diego, California

Private, non-profit minority agency providing services to minority people

Services Provided: Emergency/crisis; outreach; consultation and education; outpatient services

Ages Served: 3-18 years

Capacity: 75 children/collaterals

Total Staff: 17 (75% minority)

Population Served: 100% Asian/Pacific Islanders

Cultural Competence Training:

- Ongoing peer counseling training sessions, cultural beliefs are discussed, etc.

Treatment Philosophy:

- Provide services to those unable to use mainstream services due to cultural linguistic barriers
- Respect individual differences

Cultural Competence Strategies:

- Support the use of nontraditional helpers such as shamans, exorcists, monks, magicians and spiritual intervenors
- Community based
- Bilingual/bicultural services
- Outreach
- Concrete services
- Culturally appropriate staffing patterns
- Strict confidentiality maintained
- Linkages with community leaders, churches, temples, and organizations

AGENCY PROFILES

Union Settlement House Corporation
James Weldon Johnson Counseling Center
New York, New York

Private, non-profit agency providing bilingual/bicultural services

Services Provided: Case management; day treatment; outreach; emergency/ crisis; day treatment; outpatient services

Ages Served: 3-16 years

Capacity: 40 families/120 children

Total Staff: 21 (57% minority)

Population Served: 64% Latino/Hispanic; 35% African American; 1% Caucasian

Cultural Competence Training:

- Whole series of weekly training on cultural issues

Treatment Philosophy:

- Effective minority programs require minority staff
- Advisory group of clients
- Work in partnership with clients
- Provide cultural-specific activities

Cultural Competence Strategies:

- Recruit bilingual staff
- Shop in ethnic neighborhoods
- Understand the language
- Cultural-specific magazines and art
- Focus on family values and traditions
- Consider the influence of church and spiritualism
- Accessible location
- Receptionist has a positive attitude
- Level of acculturation is considered

Urban Indian Child Resource Center
Oakland, California

Private, non-profit minority agency providing services to minority people

Services Provided: Outreach; case management; emergency/crisis; foster care; outpatient services

Ages Served: 6-18 years

Capacity: Approximately 600 children

Total Staff: 19 (79% minority)

Population Served: 100% Native American

Cultural Competence Training:

- Culturally focused training is provided at:
  - quarterly retreats
  - staff meetings

Treatment Philosophy:

- Enable clients to take responsibility for their own behavior and problem solving
- Assist clients in making healthier choices

Cultural Competence Strategies:

- Facility decorated with Indian art
- Use of nontraditional helpers such as elders, religious leaders and healers is encouraged
- Involve young people in culture of origin to increase self-esteem and identity
- Nonverbal treatment such as play, art therapy, is encouraged
- Native American therapists
- Confidentiality is stressed
- Sponsor monthly cultural events
- Bring in "successful Indians" as speakers

AGENCY PROFILES

Vicksburg Family Development Services
Vicksburg, Mississippi

Private, non-profit agency providing services to minority people

Services Provided: Case management; home based; outreach; emergency/ crisis; parent education

Ages Served: Prenatal-4 years

Capacity: 150 families/150 children

Total Staff: 9 (66% minority)

Population Served: 97% African American; 3% Caucasian

Cultural Competence Training:

- Periodically all staff participate in inservices on working with minority families

Treatment Philosophy:

- Family-centered services
- Home-based services
- First four years of life are the most important

Cultural Competence Strategies:

- Participate in culturally specific celebrations
- Consider cultural values, such as attitude toward adoption
- Family as defined by the culture is valued
- Facility located in neighborhood
- Former clients as volunteers
- Accessible location
- Case management
- Level of acculturation is considered

DeDe Wallace Health Care System
Children and Youth Development Program
Nashville, Tennessee

Private, non-profit agency providing services to minority people

Services Provided: Case management; outpatient services; emergency/crisis; day treatment

Ages Served: 2-18 years

Capacity: 500 families/600 children

Total Staff: 60 (38% minority)

Population Served: 60% African American; 40% Caucasian

Cultural Competence Training:

- Has had one culturally focused inservice training program

Treatment Philosophy:

- Individualized treatment
- Ecological assessment
- Problem-solving approach

Cultural Competence Strategies:

- Culturally specific Christmas toys
- Emphasis on understanding family structure
- Flexibility in hours to be accessible to families
- Use of natural support systems, including churches
- Focus on child-rearing practices

AGENCY PROFILES

Warm Springs Community Counseling
Confederated Tribes of Warm Springs
Warm Springs, Oregon

Public agency supporting services by minorities within a minority community

Services Provided: Emergency/crisis; case management; outreach; outpatient services

Ages Served: 3-18 years

Capacity: 50-55 families/74 children

Total Staff: 22 (71% minority)

Population Served: 99% Native American; 1% Caucasian

Cultural Competence Training:

- Tribal government sponsors new employee orientation in which subjects such as the history of the tribe, tribal philosophy, etc., are reviewed
- On the job training

Treatment Philosophy:

- Client centered
- Encourage individual initiative
- Least restrictive setting
- Minimize government control

Cultural Competence Strategies:

- Cultural specialist
- Recognize tribal medicine societies as equal professionals
- Outreach into homes
- Use positive Indian parenting approaches
- Accessible location
- Non-intrusive
- Encourage participation in tribal activities
- Incorporate tribal experts into treatment
- Facility owned and operated by tribe

Louise Weis Services Maternity House
New York, New York

Private, non-profit agency providing services to minority people

Services Provided: Case management; therapeutic group home; prevention

Ages Served: 12-19 years

Capacity: 12 adolescents

Total Staff: 13 (77% minority)

Population Served: 80% African American; 19% Latino/Hispanic; 1% Caucasian

Cultural Competence Training:

- Training once every other month on such topics as discipline and child-rearing practices

Treatment Philosophy:

- Prevention of generational repetition of problems in offspring
- Pregnancy prevention
- Independent living
- Family oriented

Cultural Competence Strategies:

- Pamphlets in English and Spanish
- Cultural factors are assessed on admission
- Ethnic-oriented activities
- Nontraditional helpers such as midwives are used
- Linkage with churches
- Adolescents decorate their own rooms
- Level of acculturation is considered

AGENCY PROFILES

West Fulton Community Mental Health Center
Atlanta, Georgia

Public, mainstream agency supporting services by minorities within minority community

Services Provided: Case management; emergency/crisis; group home; outreach; day treatment; outpatient services

Ages Served: 0-18 years

Capacity: 200 families/200 children

Total Staff: 11 (86% minority)

Population Served: 98% African American; 2% Caucasian

Cultural Competence Training:

- Workshops and training seminars on cultural diversity
- Integrating cultural elements into treatment process
- Consultants provide training

Treatment Philosophy:

- Provide quality clinical services
- Involve child's entire environment
- Maintain family unity
- First priority is the most in need
- Prevention and outreach are key parts of service delivery

Cultural Competence Strategies:

- Include family as defined by clients' culture
- Respect values and belief system of clients and include nontraditional helpers such as ministers, godmothers, "play mothers"
- Culture-specific paintings and decorations
- Community ownership of the building
- Strong, culturally competent minority leadership
- Use of minority media
- Outreach
- Accessible location
- Minority psychiatrist on staff

Whitehaven Southwest Mental Health Center
Day Treatment, Outpatient
Memphis, Tennessee

Private, non-profit agency providing direct services to minority people

Services Provided: Case management; day treatment; outpatient services

Ages Served: 3-18 years

Capacity: 100 children

Total Staff: 9 (100% minority)

Population Served: 95% African American; 5% Caucasian

Cultural Competence Training:

- Inservice training is provided to maintain a necessary level of cultural sensitivity and awareness

Treatment Philosophy:

- Acknowledge external barriers to healthy development, such as racial, sexual and situational variables
- Program focuses on developmental mode

Cultural Competence Strategies:

- Social and cultural factors are considered in determining intervention strategies
- Outreach strategies are used in reaching "isolated" populations
- Convenient location
- Positive role models (staff)
- Use of local media

AGENCY PROFILES

Franklin Wright Settlements, Inc.
Parent Child Center
Detroit, Michigan

Private, non-profit minority agency providing services to minority people

Services Provided: Emergency/crisis; pre-Head Start; parenting and child development

Ages Served: 0-3 years

Capacity: 85 families/150 children

Total Staff: 20 (95% minority)

Population Served: 98% African American; 2% Caucasian

Cultural Competence Training:

- Not a major focus, although conscious of cultural competence issues during training sessions

Treatment Philosophy:

- Early foundation critical to successful life
- Work with parents (low income) to help with child-rearing practices in preparation for Head Start
- Program geared toward families
- Proper parenting essential to self-esteem of child

Cultural Competence Strategies:

- Base services on the needs of family
- Accessible location
- Provide concrete services

Yakima Valley Farm Workers Clinic
Day Treatment and Case Management Programs
Yakima, Washington

Private, non-profit minority agency providing services to minority people

Services Provided: Case management; day treatment; respite care; foster care; emergency/crisis; outpatient services; outreach

Ages Served: 3-18 years

Capacity: Day Treatment - 24 children/ 24 families; Case Management - 50 families/50 children

Total Staff: 14 (40% minority)

Population Served:
41.5% Latino/Hispanic; 36% Caucasian; 19% Native American; 2% Asian/Pacific Islanders; 1.5% African American

Cultural Competence Training:

- Two out of 12 inservices are on minority issues

Treatment Philosophy:

- Holistic approach
- Home based
- Start where client is
- Services based upon need

Cultural Competence Strategies:

- Respect client's belief system
- State laws for licensure require minority specialists
- Use of nontraditional helpers such as contracting with a curandero
- Teach parenting skills in Spanish
- By-laws of governing board mandates that 50% of board must be Hispanic
- Use of bilingual/bicultural psychiatrist
- Assessment tools includes items related to acculturation and assimilation
- Culturally specific snacks and toys
- Provide baby-sitting services to remove barriers to treatment

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AGENCY PROFILES

YMCA of Metropolitan Washington
YMCA Refugee Service Program
Arlington, Virginia

Private, non-profit mainstream agency supporting services by minorities within minority communities

Services Provided: Case management; after-school program; emergency/crisis; women's self-help and development; International YMCA; outreach

Ages Served: 7-18 years

Capacity: 18 families/30 children

Total Staff: 11 (100% Administrative Staff, 10% Support Staff minorities)

Population Served: 80% Asian/Pacific Islanders; 15% Latino/Hispanic; 5% African American

Cultural Competence Training:

N.A.

Treatment Philosophy:

- Identify problems through daily contact with refugee community
- Home based
- Tailor programs to meet needs

Cultural Competence Strategies:

- Respect culturally specific gender roles
- Ethnic role models
- Celebrate culturally unique holidays and events
- Community based
- Classes for home bound refugees
- Home visits
- Draw from the community to serve the community
- Accessible location
- Consider the "help seeking" behavior of clients/families

Youth Development, Inc.
Much More House Treatment
Center for Children
Albuquerque, New Mexico

Public agency providing bilingual/bicultural services

Services Provided: Group home; inpatient services; residential treatment

Ages Served: 12-17 years

Capacity: 12 families/12 children

Total Staff: 13 (38% minority)

Population Served: 60% Caucasian; 30% Latino/Hispanic; 10% Native American

Cultural Competence Training:

- Speakers brought in to assist with particular cases or cultural issues
- Staff meeting focus on cultural issues
- Retrain staff on cultural-specific issues as indicated

Treatment Philosophy:

- Nonjudgmental staff attitudes
- Utilize a variety of approaches to meet client needs
- Enhance capacity for appropriate interpersonal relationships

Cultural Competence Strategies:

- Work with ethnic-specific organizations such as Urban Indian Center, Spanish TV spots for outreach, NAACP, etc.
- Multicultural staff
- Focus on understanding different cultures and belief systems
- Respect for religious freedom
- Focus on coping in Anglo-dominated culture while enhancing identity with culture of origin
- Level of acculturation is considered
- Ethnic-specific staff assignments if indicated

Table #2

Programs by State and Racial Group Served

	African American			Asian American			Latino / Hispanic			Native American			Caucasian		
	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%
Alabama															
Insight Center, Satellite of Indian River MH/MR Center			X										X		
Arizona															
LaFrontera Center	X							X		X				X	
California															
Los Angeles Child Guidance Clinic			X	X				X					X		
San Fernando Valley Child Guidance Clinic		X		X				X		X				X	
Toiyabe Indian Health Project												X	X		
UCLA Neuro-Psychiatric Institute, Delta Sigma Theta Headstart Program			X					X					X		
Union of Pan Asian Communities Counseling & Treatment Center						X									

	African American			Asian American			Latino / Hispanic			Native American			Caucasian		
	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%
California continued.															
Urban Indian Child Resource Center												X			
Colorado															
Denver Indian Health & Family Services												X			
SERVICIOS de la Raza, Inc.	X			X					X	X			X		
Delaware															
Tressler Centers Daylight Community Program		X						X						X	
District of Columbia															
Sasha Bruce Youthwork, Inc.			X	X			X						X		
Childrens Hospital School-Based MH Program	X			X					X					X	
DC Commission on MH Services, Access Division			X				X								
DC Commission on MH Services Paul Robeson School			X												
Family Advocacy & Support Association			X										X		

	African American			Asian American			Latino / Hispanic			Native American			Caucasian		
	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%
District of Columbia continued.															
The Family Place	X								X				X		
MAAT Ctr. for Human & Organizational Enhancement			X										X		
Mother Dear's Community Center			X				X								
Florida															
Bertha Abess Children's Center Day Treatment Program		X						X						X	
So. Dade Community MH Foster Care & Project Support		X						X					X		
Georgia															
Atlanta Network Family Center, Refugee Resettlement Program		X				X								X	
Middle Georgia Council on Drugs, Governor's High Youth Teen Center			X												
So. Central Fulton MH/MR/SA Child & Adolescent Program			X				X							X	

	African American			Asian American			Latino / Hispanic			Native American			Caucasian		
	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%
Georgia continued.															
West Fulton MH/MR/SA Center, Fulton Co. Health Department			X										X		
Idaho															
Idaho Migrant Council Migrant Head Start Project									X	X			X		
Illinois															
Mujeres Latinas EN ACCION SASS (Screening, Assessment, Supportive Services)	X								X	X			X		
Massachusetts															
The Cambridge Hospital Haitian MH Clinic			100% Haitian												
La Alianza Hispana, Inc.	X								X						
Michigan															
Franklin Wright Settlements, Inc Parent Child Center			X										X		

	African American			Asian American			Latino / Hispanic			Native American			Caucasian		
	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%
Mississippi															
Exchange Club of Vicksburg Child Abuse Prevention Center		X												X	
Exchange Club Parent/Child Ctr.			X											X	
Vicksburg Family Development			X										X		
Montana															
Vurne Gibbs Health Center Fort Peck Mental Health												X			
Nebraska															
Eastern Nebraska Community		X		X			X			X					X
No. Clinic Family Counseling Svcs, Greater Omaha Com.Action			X							X				X	
New Mexico															
Youth Development, Inc. Muchmore House Treatment Ctr.								X			X				X
New York															
Fordham & Tremont Children's MH Clinic,C & A/Fam.Services		X		X					X				X		

New York continued.	African American			Asian American			Latino / Hispanic			Native American			Caucasian		
	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%
Good Shepherd Center		X						X					X		
Harlem Interfaith Counseling Services, Inc.			X				X								
Hunts Point Multi-Service Center	X								X						
Lutheran Medical Center Sunset Park MH Center	X			X					X					X	
Northside Center for Child Dev.		X						X							
Queens MH Clinic, Puerto Rican Family Institute									X						
Union Settlement House, James Weldon Johnson Counseling Ctr.		X							X				X		
L. Weis Services Maternity House			X					X					X		
North Carolina															
Blue Ridge Area MH/MR/SA Child & Fam. Svcs. Program		X								X					X
Johnston Co. MH/MR/SA Child Services Program		X		X			X			X				X	

	African American			Asian American			Latino / Hispanic			Native American			Caucasian		
	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%
North Carolina continued.															
Smoky Mountain Area MH/DD/SAS	X			X			X			X					X
Surry-Yadkin MH/MR/SA Willi M & Early Intervention		X					X								X
Trend Area MH/MR/SA		X													X
Ohio															
Central Community Health Board			X										X		
Columbus Area CMHC, MECCA (Multi-Cultural East Side Ctr. of Columbus Area)			X												
Family Resource Centers Project Inroads			X												
Franklin Co. Juvenile Court New Directions & Youth Program			X										X		
Oregon															
Confederated Tribes of Warm Springs, Warm Springs Community Counseling												X	X		

	African American			Asian American			Latino / Hispanic			Native American			Caucasian		
	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%
Rhode Island															
St. Joseph Hosp., Providence Unit, SE Asian Support Center						X									
South Dakota															
Family Services Center Red Horse Lodge, Inc.												X			
Tennessee															
Midtown MH Ctr,Child/Youth Department			X										X		
Memphis MH Institute, C & A Inpatient Psychiatric Unit			X	X										X	
Payne Chapel AME Church Alcoholism Screening, etc.			X												
Tri County Children/Fam. Svcs.			X										X		
DeDe Wallace Hlth. Care Sys.			X											X	
White Haven SW MH Center			X										X		

	African American			Asian American			Latino / Hispanic			Native American			Caucasian		
	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%	Under 10%	10% to 50%	Over 50%
Utah															
Indian Walk-In Center	X			X				X			X			X	
Salt Lake Valley MH Refugee MH Program						X									
Virginia															
Community Based Svcs. Family Advocacy Program		X		X				X						X	
Connections/Catholic Charities	X					X		X					X		
YMCA of Metro. Washington, YMCA Refugee Svc. Program	X					X		X							
Washington															
Colville Tribes MH Program												X	X		
Okanogan Co. MH Okanogan Co. RE-ED Program												X		X	
Yakima Valley Farm Workers Clinic MH Services	X			X				X			X			X	

APPENDIX III

List of Programs/Agencies Participating in the Study

Program Descriptions

Brief Profiles

LIST OF PROGRAMS/AGENCIES

Program Descriptions

1. Asian/Pacific Center for Human Development
   1825 York Street
   Denver, Colorado 80206
   Contact: Executive Director, 303-355-0304

2. Black Family Development
   15231 W. McNichols
   Detroit, Michigan 48235
   Contact: Executive Director, 313-272-3500

3. Roberto Clemente Family Guidance Center
   540 East 13th Street
   New York, New York 10009
   Contact: Director, 212-477-8210

4. The Indian Health Board of Minneapolis, Inc.
   The Soaring Eagles Program
   1315 E. 24th Street
   Minneapolis, Minnesota 55404
   Contact: Director, 612-721-3765

5. Ada S. McKinley Community Services
   Ada S. McKinley Intervention Services
   2515 17 West 63rd Street
   Chicago, Illinois 60629
   Contact: Division Director, 312-434-5517

6. Progressive Life Center, Inc.
   1123 11th Street, NW
   Washington, DC 20001
   Contact: Executive Director, 202-842-4570

7. Roybal Family Mental Health Services
   Utah Street School Co location Project
   245 South Fetterly Avenue
   Los Angeles, California 90022
   Contact: Project Coordinator, 213-780-2316

8. Santa Clara County Mental Health Bureau
   645 South Bascom Avenue
   San Jose, California 95128
   Contact: Ethnic Pop. Specialist, 408-299-5935

9. South Cove Community Health Center
   885 Washington Street
   Boston, Massachusetts
   Contact: Executive Director, 617-482-7555

10. Three Rivers Youth
    2039 Termon Avenue
    Pittsburgh, Pennsylvania 15212
    Contact: Executive Director, 412-766-2215

11. U.S. Public Health Service
    Indian Health Service/Yakima Service Unit
    Mental Health/Social Service Dept.
    Yakima Indian Reservation
    401 Buster Road
    Toppenish, Washington 98948
    Contact: Director, 612-721-3765

Brief Profiles

1. Bertha Abess Children's Center, Inc.
   2600 SW 2nd Avenue
   Miami, Florida 33129
   Contact: Executive Director, 305-858-7800

2. Atlanta Network Family Center
   Refugee Resettlement Program
   Families in Transition
   1864 Independence Square
   Atlanta, Georgia 30338
   Contact: Director, 404-668-0350

3. Blue Ridge Area MH/MR/SA Program
   Child and Family Services Program
   356 Biltmore Avenue
   Asheville, North Carolina 28801
   Contact: Director, 704-258-2597

4. Sasha Bruce Youthwork, Inc.
   1022 Maryland Avenue, NE
   Washington, DC 20002
   Contact: Executive Director, 202-675-9350

5. The Cambridge Hospital
   Haitian Mental Health Clinic
   1493 Cambridge Street
   Cambridge, Massachusetts 02139
   Contact: Director, 617-498-1148

6. Central Community Health Board
   Children's Services
   530 Maxwell Avenue
   Cincinnati, Ohio 45219
   Contact: Director, 513-559-2002

7. Children's Hospital
   School Based Mental Health Program
   111 Michigan Avenue, NE
   Washington, DC 20010
   Contact: Director, 202-745-5550

8. Columbus Area Community Mental Health Ctr.
MECCA (Multi Cultural East Side Center
of Columbus Area)
1515 East Broad Street
Columbus, Ohio 43205
Contact: Clinical Director, 614-251-2334

9. Colville Tribes Mental Health Program
P.O. Box 150
Nespelem, Washington 99155
Contact: Social Worker, 509-634-4787

10. Community Based Services, Inc.
Family Advocacy Program
4032 Williamsburg Court
Fairfax, Virginia 22032
Contact: Regional Director, 703-591-2877

11. Connections/Catholic Charities
701 West Broad Street
Suite #305
Falls Church, Virginia 22046
Contact: Regional Director, 703-533-3302

12. D.C. Commission on Mental Health Services
Access Division
1905 E Street, SE
Washington, DC 20003
Contact: Unit Director, 202-727-6944

13. D.C. Commission on Mental Health Services
Paul Robeson School
for Growth and Development
Child/Youth Services Administration
3700 10th Street, NW
Washington, DC 20010
Contact: Program Manager, 202-576-7154

14. Denver Indian Health & Family Services
Mental Health Program
1739 Vine Street
Denver, Colorado 80206
Contact: Project Director, 303-320-3974

15. Eastern Nebraska Community Office of
Mental Health Youth Services
885 S. 72nd Street
Omaha, Nebraska
Contact: Executive Director, 402-444-6656

16. Exchange Club of Vicksburg
Child Abuse Prevention Center
P.O. Box 1887
Vicksburg, Mississippi 39180
Contact: Director, 601-634-0557

17. Exchange Club Parent/Child Center
2906 N. State, Suite 200
Jackson, Mississippi 39205
Contact: Acting Director, 601-366-0025

18. Family Advocacy & Support Association, Inc.
3649 New Hampshire Avenue, NW
Washington, DC 20010
Contact: President, 202-291-4979

19. The Family Place
3309 16th Street, NW
Washington, DC 20010
Contact: Director, 202-232-2631

20. Family Resource Centers - Project Inroads
799 South Main Street
Lime, Ohio 45804
Contact: Program Supervisor, 419-222-1168

21. Family Service Center
Red Horse Lodge, Inc.
Box 49
Fort Thompson, South Dakota 57339
Contact: Director, 605-245-2213

22. Fordham & Tremont CMHC
Child, Adolescent & Family Services Division
2021 Grand Concourse
Bronx, New York 10453
Contact: Division Director, 212-960-0341

23. Franklin County Juvenile Court
New Directions and Youth Leadership Program
610 Van Buren Drive
Columbus, Ohio 43223
Contact: Director, 614-469-7140

24. Vurne Gibbs Health Center
Fort Peck Mental Health
P.O Box 67
Poplar, Montana 59255
Contact: Director, 406-768-3491

25. Good Shepherd Center
Marion Hall Facility
337 E. 17th Street
New York, New York 10003
Contact: Program Director, 212-475-4245

26. Greater Omaha Community Action, Inc.
North Clinic Family Counseling Services
2826 Ames Avenue
Omaha, Nebraska
Contact: Clinical Director, 402-451-2935

27. Harlem Interfaith Counseling Service, Inc.
215 West 125th Street
New York, New York 10027
Contact: Asst. Clinical Director, 212-662-8613

28. Hunts Point Multi-Service Center
630 Jackson Avenue
Bronx, New York 10455
Contact: Executive Director, 212-402-8899

29. Idaho Migrant Council
Migrant Head Start Project
P.O. Box 490
Caldwell, Idaho 83606
Contact: Health Specialist/Coord., 208-454-1652

30. Indian River MH/MR Center
Insight Center
3028 Short 19th Street
Tuscalousa, Alabama 35401
Contact: Coordinator of Services, 205-345-0661

31. Indian Walk-In Center
120 W. 1300 South
Salt Lake City, Utah 84115
Contact: Director, 801-486-4871

32. Johnston County MH/MR/SA
Child Services Program
P.O. Box 411
Smithfield, North Carolina 27577
Contact: Coordinator, 919-934-5121

33. La Alianza Hispana, Inc.
409 Dudley Street
Roxbury, Massachusetts 02119
Contact: Executive Director, 617-427-7175

34. La Frontera Center
Mental Health & Substance Abuse Services
502 W. 29th Street
Tucson, Arizona 85745
Contact: Executive Director, 602-884-9920

35. The Los Angeles Child Guidance Clinic
Day Treatment Programs/Non-Public School
746 West Adams Boulevard
Los Angeles, California 90007
Contact: Director, Clinical Svcs., 213-749-4111

36. Lutheran Medical Center
Sunset Park Mental Health Center
514 49th Street
Brooklyn, New York 11220
Contact: Director, 718-854-1851

37. MAAT Center for Human
and Organizational Enhancement
1914 9th Street, NW, Suite #2
Washington, DC 20001
Contact: Executive Director, 202-265-0296

38. Memphis M.H. Institute
Child & Adolescent Inpatient Psychiatric Unit
P.O. Box 40966
865 Poplar Avenue
Memphis, Tennessee 38174
Contact: Program Director, 901-524-12009

39. Middle Georgia Council on Drugs
Music-Oriented Values Education Program
Governor's High Risk Youth Teen Center
538 First Street
Macon, Georgia 31201
Contact: Executive Director, 912-743-4611

40. Midtown Mental Health Center
Children & Youth Department
427 Linden Avenue
Memphis, Tennessee 38116
Contact: Coordinator, 901-577-0200

41. Mother Dear's Community Center
467 Florida Avenue, NW
Washington, DC 20001
Contact: Director, 202-387-5129

42. Mujeres Latinas EN ACCION
SASS (Screening, Assessment,Supportive Svcs.)
1823 W. 17th
Chicago, Illinois 60608
Contact: Coordinator, 312-226-1544

43. Northside Center for Child Development
1301 Fifth Avenue
New York, New York 10029
Contact: Deputy Director, 212-860-1616

44. Okanogan County Mental Health
Okanogan County RE-ED Program
P.O. Box 3208
Omar, Washington 98841
Contact: Co-Director, 509-826-0926

45. Payne Chapel, AME Church
Alcoholism Screening & Knowledge
204 Neil Avenue
Nashville, Tennessee 37206
Contact: Assistant Director, 615-262-1601

46. Puerto Rican Family Institute, Inc.
Queens Mental Health Clinic
116 West 14th Street
New York, New York 10011
Contact: Program Director, 718-899-5212

47. Salt Lake Valley Mental Health
Refugee Mental Health Program
145 East 1300 South #501
Salt Lake City, Utah 84106
Contact: Unit Manager, 801-539-7000

48. San Fernando Valley Child Guidance Clinic
9650 Zelzah Avenue
Northridge, California 91325
Contact: Hispan. Outreach Coord., 818-993-9311

49. SERVICIOS de la Raza, Inc.
Youth Services Division
4055 Tejon Street
Denver, Colorado 80211
Contact: Executive Director, 303-458-5851

50. Smoky Mountain MH/DD/SAS
P.O. Box 280
Dillsboro, North Carolina 28725
Contact: Director, Mental Health, 704-586-4646

51. South Central Fulton MH/MR/SA
Child & Adolescent Program
215 Lakewood Way, SW
Atlanta, Georgia 30315
Contact: Coordinator, 404-627-0825

52. South Dade Community Mental Health
Therapeutic Foster Care & Project Support
10300 SW 216 Street
Miami, Florida 33190
Contact: Children Svcs. Coord., 305-252-2625

53. St. Joseph Hospital, Providence Unit
South East Asian Support Center
21 Peace Street
Providence, Rhode Island 02907
Contact: Program Coordinator, 401-456-4423

54. Surry - Yadkin Area MH/MR/SA
Willie M & Early Intervention Programs
P.O. Box 818
Yadkinville, North Carolina 27055
Case Manager Supervisor, 919-789-5011
Contact: Early Intervention Dir., 919-679-8805

55. Toiyable Indian Health Project
Family Services Program
P.O. Box 1296
Bishop, California 93514
Contact: Case Supervisor, 619-873-6394

56. Trend Area MH/MR/SA
Family Resource Program
Gaston & Morgan Streets
Brevard, North Carolina 28712
Contact: Program Director, 704-884-2027

57. Tressler Centers
Daylight Community Program
10th & Walnut Streets, YMCA
Wilmington, Delaware 19801
Contact: Director, 302-428-3775

58. Tri-County Children/Family Services
420 Long Avenue
P.O. Box 45
Covington, Tennessee 38019
Contact: Executive Director, 901-476-2364

59. UCLA Neuro-psychiatric Institute
Delta Sigma Theta Head Start Program
760 Westwood Plaza
Los Angeles, California 90024
Mental Health Screening
Contact: Program Director, 213-825-0075

60. Union of Pan Asian Communities
Counseling & Treatment Center
1031 25th Street
San Diego, California 92102
Contact: Program Director, 619-235-4282

61. Union Settlement House
James Weldon Johnson Counseling Center
2089 3rd Avenue
New York, New York 10029
Contact: Administrative Director, 212-876-0300

62. Urban Indian Child Resource Center
390 Euclid Avenue
Oakland, California 94610
Contact: Executive Director, 415-832-2386

63. Vicksburg Family Development Service
P.O. Box 64
Vicksburg, Mississippi 39181
Contact: Administrative Director, 601-638-1336

64. DeDe Wallace Center
Children & Youth Development Program
220 Hillsboro Road
P.O. Box 120219
Nashville, Tennessee 37212
Contact: Vice President, 615-227-5982

65. Warm Springs Community Counseling
Confederated Tribes of Warm Springs
P.O. Box C
Warm Springs, Oregon 97761
Contact: Director, 503-553-3205

66. Louise Weis Services Maternity Home
314 West 82nd Street
New York, New York 10024
Contact: Resident Manager, 212-877-3317

67. West Fulton MH/MR/SA Center
Fulton County Health Department
475 Fairburn Road, SW
Atlanta, Georgia 30331
Contact: Director, 404-691-9627

68. Whitehaven SW Mental Health Center
Day Treatment and Outpatient Programs
1087 Alice Avenue
Memphis, Tennessee 38106
Contact: Program Director, 901-525-2082

69. Franklin Wright Settlements, Inc.
Parent Child Center
5245 Concord
Detroit, Michigan 48211
Contact: Program Director, 313-571-2680

70. Yakima Valley Farm Workers Clinic
Mental Health Services
P.O. Box 190
32 North 3rd Street, Suite 326
Yakima, Washington 98948
Contact: Program Director, 509-453-1344

71. YMCA of Metropolitan Washington
YMCA Refugee Services Program
3422 North 13th Street
Arlington, Virginia 22201
Contact: Director, 703-841-9465

72. Youth Development, Inc.
Muchmore House Treatment Center
for Children
1710 Centro Familiar SW
Albuquerque, New Mexico 87105
Contact: Program Director, 505-877-7318

APPENDIX IV

Culturally Competent Training Institute Faculty List

FACULTY LIST

Training Institutes: Towards a Culturally Competent System of Care for Children of Color

July 22-26, 1990

Boulder, Colorado

Plenary Speakers and Moderators

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The Honorable Wilma J. Webb
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INSTITUTES

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Three Rivers Youth
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Health Track Institute
Developing Culturally Competent Programs for Children with Special Health Care Needs (#7+ #14)

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Training For Cultural Competence (#13)

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